PAHOA ANIMAL HOSPITAL
15-2714 PAHOA VILLAGE RD UNIT C3
Pahoa, HI 96778
(808) 930-5888

Welcome

REGISTRATION

Owner: _____ **Date:** _____

Residental Address: _____ **Employer:** _____

_____

Mailing Address: _____ **Drivers License #:**

_____

Email Address: _____ _____

Phone: _____ **Work Phone:** _____ _____

Emergency Contact Name: _____ **Phone** _____

How did you learn about our clinic? ☐ Sign Outside ☐ Radio ☐ Facebook ☐ Recommendation ☐ Website ☐ News Paper ☐ Other: _____

If recommended, by whom? _____

Number of Pets **Dogs:** _____ **Cats:** _____ **Other (Specify):** _____

Pet Co-Owners and Relationship: _____

PET HEALTH HISTORY

Name of Pet: _____ ☐ Dog ☐ Cat ☐ Other: _____

Breed: _____ **Color:** _____ **Birthdate:** _____

☐ Undetermined ☐ Male ☐ Neutered ☐ Female ☐ Spayed

Vaccination History (date and type of last vaccinations): _____

_____

_____

_____

Pet's current medications: _____

Describe your pet's diet: _____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and/or treat my pet(s). I assume full responsibility for all charges incurred for the care of my pet(s). I also understand that these charges will be paid at the time of service and that a deposit may be required for treatment.
I authorize Pahoa Animal Hospital to take photos of my pets to use in their medical record.
I acknowledge that I can request or view a copy of the Hospital Policies on the Pahoa Animal Hospital website and I agree to its terms.

Signature of Owner: _____ **Date:** _____

Method of Payment: ☐ Cash ☐ Debit ☐ Credit ☐ Care Credit ☐ Other: _____