WELCOME TO
TORO PARK ANIMAL HOSPITAL

Owner Name: _____ **Spouse/Other:** _____

Mailing Address:_____

City:_____ **State:** _____**Zip code:** _____

Home #:_____**Cell #:**_____ **Driver's License #:**_____

Employer: _____**Work #:** _____

Spouse/Other Employer: _____**Work #:** _____

Email Address: _____

We will gladly prepare a written estimate for all medical and surgical procedures. This will be important to you since ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. In cases of extensive medical or surgical procedures, when full payment may be difficult at discharge, we accept Master Card, and Visa. There will be a $25.00 service charge for any check returned unpaid.

To prevent the spread of infectious diseases, all hospitalized and boarded patients must be current on all vaccines and free from internal and external parasites. The signature below authorizes this level of preventative care and the appropriate charges will be assessed in the discharge invoice.

Signature of Responsible Agent for Pet(s): _____

Date: _____

How/Why did you select us? _____

If referred, whom may we thank? _____

ESSENTIAL ANIMAL INFORMATION

Name	Species	Breed	DOB/Year	Sex/Altered	Color