

ANIMAL MEDICAL CENTER

25848 McBean Parkway

Valencia, CA 91355

Ph: (661)255-5555 Fax: (661) 288-2266

CLIENT INFORMATION

Please complete the following:

Your Name: _____
Last First Middle

Spouses Name: _____ Home Phone Number: (____) _____

Address: _____
Street City Zip Code

Email Address: _____ Cell Phone Number: (____) _____

Your Place of Work: _____ Work Phone Number: (____) _____

How did you learn about our clinic? _____
Advertisement Referred By: _____
Phone Book Sign

Drivers License Number: _____ (NEEDED FOR CARE)

Social Security Number: _____ - _____ - _____ (CHECKS WONT BE ACCEPTED WITHOUT IT)

WOULD YOU LIKE US TO SEND ANY RECORDS TO ANOTHER VET? _____

IF SO, NAME: _____

PHONE #? _____

I hereby authorize the veterinarian to examine, prescribe for, and/or treat my pet. I assume full responsibility for all charges incurred for the care of my pet. I also understand that all fees are due at time of services rendered, and Valencia Veterinary Center does not bill or extend credit for any reason. Valencia Veterinary Center will discuss all fees prior to doctor visit when asked.

YOUR SIGNATURE: _____

PETS NAME: **#1** _____ **#2** _____ **#3** _____ **#4** _____

BREED			
DOB			
COLOR			
SEX			
SPAYED/NEUTERED?	CIRCLE ONE YES/NO		
VACCINATION HISTORY- Current?	CIRCLE ONE YES/NO		

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medicines? _____

Is your pet on any special diet or medications? _____

Does your pet have a Microchip? # _____