# 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: _____ Cell Phone Number: (_____) _____

Address: _____
**Street** **City** **Zip Code**

Email Address: _____ Home 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)

Date Of Birth:_____

**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 Animal Medical Center does not bill or extend credit for any reason. Animal Medical 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? #**_____