



NEW CLIENT FORM

VETERINARY HEALTHCARE CENTER
241 WEST POMONA BLVD.
MONTEREY PARK, CA 91754
(323) 890-9000
WWW.VHC.LA

(ALL INFORMATION MUST BE COMPLETED BEFORE ACCEPTING AS A CLIENT.)

CLIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

SPOUSE'S NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _(_____) _____ CELLULAR PHONE: _(_____) _____

E-MAIL ADDRESS: _____

CALIFORNIA DRIVER'S LICENSE: _____ EXPIRATION: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S PHONE NUMBER: _(_____) _____ EXTENSION: _____

PLEASE INDICATE PREFERRED TYPE OF PAYMENT: CASH/CHECK VISA/MC AMEX/DISCOVER

HOW DID YOU LEARN OF OUR CLINIC? YELLOW PAGES CLIENT WALK-IN YELP

REFERRED BY: _____

PATIENT INFORMATION

	PET #1	PET #2	PET #3	PET #4
NAME				
SPECIES				
BREED				
DATE OF BIRTH				
COLOR				
SPAYED OR NEUTERED?				
MALE OR FEMALE?				
RABIES VACCINE DATE				
OTHER VACCINATIONS?				

AUTHORIZATION

(PLEASE READ CAREFULLY)

I CERTIFY THAT I OWN THE ABOVE DESCRIBED ANIMAL(S). I DO HEREBY AUTHORIZE VETERINARY HEALTHCARE CENTER AND ITS STAFF TO ADMINISTER VACCINATIONS, MEDICATIONS, TESTS, TREATMENTS, SURGICAL PROCEDURES, AND TO HOSPITALIZE MY PET IF THE DOCTORS DEEM IT NECESSARY FOR THE HEALTH, SAFETY, OR WELL-BEING OF THE ABOVE ANIMAL(S) WHILE THEY ARE UNDER THEIR CARE AND SUPERVISION. EXCEPT IN DIRE EMERGENCIES ALL TREATMENTS AND PROCEDURES WILL BE DISCUSSED WITH ME PRIOR TO IMPLEMENTATION. I ALSO ACCEPT FULL FINANCIAL RESPONSIBILITY AND WILL PAY FOR ALL PROCEDURES AND TREATMENTS IN FULL AT THE TIME THE ANIMAL IS DISCHARGED. LASTLY, I FURTHER AGREE THAT A FINANCE CHARGE OF 1½% PER MONTH (18% PER ANNUAL) MINIMUM CHARGE, BUT NOT LIMITED TO \$5.00 SHALL BE ADDED TO MY ACCOUNT SHOULD MY PAYMENT NOT BE RECEIVED ON TIME. THIS AUTHORIZATION WILL REMAIN IN PLACE FOR THE LIFE OF THE ANIMAL UNLESS REVOKED IN WRITING BY THE CLIENT.

SIGNATURE OF CLIENT: _____ DATE: _____

RECEPTIONIST'S INITIALS: _____