



CLIENT INFORMATION

2310 Faraday Avenue
Carlsbad, CA 92008
Phone: (760) 431-2273
Fax: (760) 431-1084

100 N. Rancho Santa Fe Road
Suite 133
San Marcos, CA 92069
Phone: (760) 734-4433
Fax: (760) 734-6523

25100 Hancock Avenue
Suite 116
Murrieta, CA 92562
Phone: (951) 600-9803
Fax: (951) 600-7758

Please print the following information:

Client ID: _____

Staff Initials: _____

Primary Care Veterinarian: _____

Hospital Name: _____

Owner's Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Employer: _____

Spouse/Co-owner Name (If not applicable please write N/A): _____

If paying by check please include the following:

Driver's Licence: _____ DOB: _____

Pet's Name: _____ Dog Cat Other _____

Breed: _____ Sex: Male Neutered Female Spayed

Color: _____ Age or DOB: _____

Reason for Visit: _____

Current medications: _____

Allergic to any medications: _____

Past problems or current treatment: _____

My pet has a tendency to [circle]: bite **YES** **NO** scratch **YES** **NO**

By signing below you are consenting to the examination and treatment of your pet and acknowledging that you will be financially responsible for the fees incurred for the patient described herein. You may ask for an estimate of anticipated fees before treatment begins. A deposit will be required for all hospitalized patients. All charges must be paid at the time the animal is released. There are no guarantees or assurances of the outcome from any examination or treatment provided. Unless otherwise stated, you are giving CVS permission to release the medical record of this patient.

X: _____ **Date:** _____
Signature