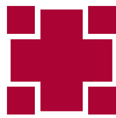

NEW CLIENT FORM

Thank you for giving us the opportunity to care for your pet.
Please complete the following, so that we may become better acquainted:

Owner's Name ____________________

Other Authorized Agent ____________________

Home Address ____________________ City ____________________ St ________ Zip ____________

Home Phone # (   ) ____________________ Cellular # (   ) ____________________

Best Number to Reach You (   ) ____________________ Fax # (   ) ____________________

Email Address ____________________

Employer ____________________ Occupation ____________________

Address ____________________ Phone (   ) ____________________

How did you hear about us? ____________________

PET INFORMATION

Please complete the following for the pet we are seeing today:

Name of Pet ____________________ Dog / Cat / Other Breed ____________________

Date of Birth ____________________ Gender ____________________ Spayed/Neutered ____________

Color ____________________ Is your pet current on vaccinations? ____________________

Referring Doctor(s) ____________________

Referring Veterinary Facility ____________________

Have you been to City of Angels before? ____________________ Which Practice? ____________________

What is the reason for your visit? ____________________

Known drug allergies: ____________________

Medications your pet is currently taking:

____

____

- ❑ YES. Please share my information with other City of Angels practices in the event that my pet may need their services.
- ❑ YES. I authorize and direct the veterinarians at City of Angels to diagnose, prescribe, perform therapeutic procedures, and/or surgery that their judgment may dictate to be advisable for the patients well being. No warranty or guarantee has been made as to the result or cure.

Client Signature ____________________ Date ____________________

Individually owned and operated practices at City of Angels: