

VETERINARY MEDICAL CENTER, STUDIO CITY
REGISTRATION

Please provide us with the following information so that we may provide you and your pet with the finest service possible.

Your Name _____ Spouse _____
Mr. Mrs. Ms. Dr. FIRST LAST
Home Address _____ Apt # _____
City _____ State _____ Zip Code _____
Home phone # () _____ - _____ Work phone # () _____ - _____
Cell Phone # () _____ - _____ Fax () _____ - _____ E-mail _____
How Do You Most Prefer To Be Contacted? Home Work Fax Cell E-mail
Employer _____ Occupation _____
Work Address _____
City _____ State _____ Zip Code _____
Preferred Payment Method? Cash Check Visa Master Card
Driver's License Number _____ Date of Birth _____
Social Security Number: _____
In case of an emergency, who may we contact if we are unable to reach you?
Name _____ Phone () _____
Do you authorize this person to make treatment decisions and/or add patients to your file?
 YES NO

How did you hear about us? (please mark all that apply)

Yellow Pages Television Vaccine Clinic Saw Sign Newspaper Article
 Magazine (which one?) _____
 Friend (who?) _____
 Veterinarian (who?) _____
 Pet Store / Groomer (who?) _____
 Other _____

I hereby authorize Veterinary Medical Center, Studio City its employees and/or representatives to render medical and surgical care for my pet(s) as deemed necessary by the veterinarian. I understand that payment for treatment, diagnostic tests and/or surgery performed is required in full upon discharge and I accept full financial responsibility.

Signature _____ Date _____

Please provide us the following information about your pet(s):

	Pet #1	Pet #2	Pet #3	Pet #4
Name				
Species				
Breed				
Sex	M F	M F	M F	M F
Date of Birth				
Neutered/Spayed?	Y N	Y N	Y N	Y N
Color				
Vaccines Due				

Does your pet have any special conditions or needs of which we should be aware? YES NO

If yes, please explain:

Do you have any special needs, concerns, or attributes you would like to discuss?