Client Information

Last Name: _____First:_____MI:___

Spouse/Partner: Last Name_____First:_____MI:___

Street Address: _____ Apt#:_____ City: _____ Zip: _____

Home Phone #:_____ Cell Phone #:_____ Work Phone#_____

Preferred Method of Contact: Home #_____ Cell#_____ Work#_____

Spouse/Partner Cell Phone#:_____ Work #:_____

Email Address: _____ Date of Birth___/___/____

How did you hear about us? _____

Patient Information

Name: _____ Sex: ___ Neutered/Spayed? ____ Birthdate: __/__/____

Breed: _____ Color: _____

Vaccination History____

Dogs	Cats
Rabies __/__/____ 1 Year or 3 Year	Rabies __/__/____ 1 Year or 3 Year
DHLPP __/__/____ 1 Year or 3 Year	FVRCP __/__/____ 1 Year or 3 Year
Bordetella__/__/____	FIV __/__/____
Lyme __/__/____	FELV__/__/____

Any Known Medical Conditions or Allergies?

_____

Authorization:

I hereby authorize the Veterinarians at Mt. Diablo Veterinary Medical Center to examine, prescribe and treat my pets. I assume responsibility for all charges incurred for the care of my animal(s). I also understand charges are due the day of service.

Staffing Disclosure

Veterinary medical service is provided during the nighttime hours as necessary under the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided. Please acknowledge your receipt and understanding of the foregoing by signing and dating this form on the lines indicated below.

Signature: _____ Date_____

(Office use: entered: ___checked___kit___date_____