MURRIETA OAKS VETERINARY HOSPITAL
PHONE (951) 677-7007 FAX (951) 677-4779
NEW CLIENT INFORMATION

Thank you for choosing our hospital to care for your pets!
We look forward to serving you and your pets. We would greatly appreciate some background information on you and your pets.

Last name: _____ First name :_____

Address: _____ Apt. _____Home phone: _____

City: _____State_____ Zip_____cell #: _____

Spouse name_____ **Your date of birth** _____

**** This information is required by law for certain medications to be prescribed for your pet.***

Email: _____

****Murrieta Oaks Veterinary Hospital operates in accordance to federal HIPAA act; We will never sell or distribute your private information to any 3rd party.***
E-MAIL IS FOR VETERINARY MEDICAL PURPOSES ONLY.

How did you become aware of our clinic? _____

1st Patient Information **Check - In**

Name:_____ Sex: Male _____ Neutered Y or N Weight_____

Birthdate or Age _____ Female _____ Spayed Y or N Temp. _____

Breed _____ Color _____

2nd Patient Information

Name:_____ Sex: Male _____ Neutered Y or N Weight_____

Birthdate or Age _____ Female _____ Spayed Y or N Temp. _____

Breed _____ Color _____

3rd Patient Information

Name:_____ Sex: Male _____ Neutered Y or N Weight_____

Birthdate or Age _____ Female _____ Spayed Y or N Temp. _____

Breed _____ Color _____

Vaccination History

Do you have documents showing your pet's vaccine history with you? Y or N

If you do not have the vaccine history documents, what Animal Hospital or Veterinary Clinic would have the most up to date vaccine history and /or medical history for your pets?

Animal Hospital Name and town or city: _____

Animal Hospital Phone Number if you know: _____

ALL FEES ARE DUE AND PAYABLE UPON COMPLETION OF SERVICE

Method of payment: Cash__Visa__MC___Debit__Discover___ We Do Not Accept Checks!

I understand that every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed above. Furthermore, I agree to pay fees for all services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection, attorney fees and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the hospital is located. I understand that veterinary service is provided during nighttime hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided. I am at least 18 years of age and legally liable for any decisions I make.

Signature: _____Date: _____