CENTRAL COAST
PET EMERGENCY HOSPITAL

New Client Information Form

Please complete all questions below.

- **Owner's Full Name:**

  _____

  Tel: (Primary)_____ **Tel: (Secondary)**_____

  Email Address:_____

  Home Address:_____

  City: _____**State:** _____ **Zip**:_____

  Owner's date of birth: **Month/Day/Year** _____

The DEA requires the date of birth of pet owners in order for medications to be dispensed.

- **Authorized Secondary Account Holder**: Do you have someone who can be contacted to authorize treatment changes if you are unreachable? .....Yes ☐ No ☐

  Name of Seconday Account Holder: _____

  Tel: (Primary)_____ **Tel: (Secondary)**_____

- **Primary Veterinarian(s):**_____

  Primary Hospital/Practice(s):_____

  Other veterinarians or specialty animal hospitals your pet has been treated by? _____

- **Pet's Name:** _____

  Species: Dog  **Cat**  **Male** _____ **Is he neutered ?** **Yes**  **No** 

  Female_____ **Is she spayed ?** **Yes**  **No** 

  Breed:_____**Color:**_____

  Approximate age/ date of birth of your pet:_____

  Medications your pet is currently taking: _____

  Are your pet's vaccines current? _____ **Is your pet microchipped?**_____

  Have you been to Central Coast Pet Hospital in the past? _____

  How did you hear about Central Coast Pet Hospital ? _____

- **I authorize and direct the veterinarians at Central Coast Pet Emergency Clinic, Inc. to diagnose, prescribe, and perform minor therapeutic procedecures that their judgement may indicate to be adviseable for the patient's well being. No warranty or guarantee has been made as to the result or cure, and I understand I am financially reponsible for authorized services performed.**
  Please Print Name: _____

  Client or Authorized Party Signanature:_____**Date:**_____

Internal use only: Admission time: _____ Client# _____Patient#_____