

## **Client Information Form**

Veterinary Healthcare Center 241 West Pomona Blvd. Monterey Park, CA 91754 (323) 890-9000 www.vhc.la

(ALL Information  $\underline{\mathsf{MUST}}$  Be Completed Before Accepting As A Client.)

## CLIENT INFORMATION (PLEASE PRINT)

Required if polymoral protects	DATE OF BIRTH:  (Required for dispensing of certain controlled medications)		FIRST NAME:		M.I.:	
COOWNER: LAST NAME: FIRST NAME: RELATION:  ADDRESS: ZIP CODE:   HOME PHONE: ZIP CODE:   HOME PHONE: ZIP CODE:   HOME PHONE: ZIP CODE:   EMERGENCY CONTACT NAME: PHONE:   EMERGENCY SIZE STATE: EXPIRATION:   EMPLOYER'S LICENSE: STATE: EXPIRATION:   EMPLOYER'S PHONE NUMBER:   EMPLOYER'S PHON			LAST FOUR DIGITS OF SOCIAL SECURITY:			
CITY:	( - 4 5 4 3 - 5					
EMERGENCY CONTACT NAME:	Address:					
EMERGENCY CONTACT NAME:	Спу:		STATE:	ZIP CODE:		
EMAIL ADDRESS:	HOME PHONE: ()		CELLULAR PHONE: ()			
EMAIL ADDRESS:	EMERGENCY CONTACT NAME:		PHONE: ()			
DRIVER'S LICENSE: STATE: EXPIRATION:  EMPLOYER'S NAME:  EMPLOYER'S PHONE NUMBER: (						
EMPLOYER'S PHONE NUMBER:					<del></del> :	
EMPLOYER'S PHONE NUMBER: (						
PLEASE INDICATE PREFERRED TYPE OF PAYMENT:   CASH/CHECK   VISA/MC   AMEX/DISCOVER HOW DID YOU LEARN OF OUR CLINIC?   PETHENT INFORMATION  PATIENT INFORMATION  PET#1 PET#2 PET#3 PET#4  NAME  SPECIES  BREED  DATE OF BIRTH  COLOR  SPAYED OR NEUTERED?  MALE OR FEMALE?  RABIES VACCINE DATE  OTHER VACCINATIONS?  AUTHORIZATION  (PLEASE READ CAREFULLY)  LERRIFY THAT I OWN THE ABOVE DESCRIBED ANIMAL(S). I DO HEREBY AUTHORIZE VETERINARY HEALTHCARE CENTER AND ITS STAFF TO ADMINISTER VACCINATIONS, MEDICATIONS, TESTS, TREATMENTS, SURGICAL PROCEDURES, AND TO HOSPITALIZE MY PET IF THE DOCTORS DEEM IT MECESSARY FOR THE HEALTH, SAFETY, OR WELL-BEINS OF THE ABOVE ANIMAL(S) WHILE THEY ARE UNDER THEM CORRES AND TO HOSPITALIZE MY PET IF THE DOCTORS DEEM IT MECESSARY FOR THE HEALTH, SAFETY, OR WELL-BEINS OF THE ABOVE ANIMAL(S) WHILE THEY ARE UNDER THEM PET ON THE ABOVE DESCRIBED ANIMAL SHAPETY, OR WELL-BEINS OF THE ABOVE ANIMAL(S) WHILE THEY ARE UNDER THEM PET ON THE ABOVE DESCRIBED WITH ME PRIOR TO IMPLEMENTATION. I UNDERSTAND THAT I WAY BE REQUIRED TO TRANSFER MY PET TO ANOTHER FACILITY IF A PIEURIS CARE IS NECESSARY. I ALSO ACCEPT FULL FINANCIAL RESPONSIBILITY AND WILL PAY FOR ALL PROCEDURES AND TREATMENTS IN PULL AT THE TIME THE ANIMAL IS DISCHARGED. I UNDERSTAND THAT I WAY PERSONAL INFORMATION WILL NOT BE SHARED OR SOLD TO ANY THIRD PARTY AND WILL BE REPORTED TO SANCHER FASHED OR SOLD TO ANY THIRD PARTY AND WILL BE REPORTED TO SANCHER FASHED OR SOLD TO ANY THIRD PARTY AND WILL BE REPORTED TO SANCHER PROCEDURES SAND TREATMENTS IN PULL AT THE TIME THE ANIMAL IS DISCHARGED. I UNDERSTAND THAT I WAY PERSONAL INFORMATION WILL NOT BE SHARED OR SOLD TO ANY THIRD PARTY AND WILL BE ADDED TO MY ACCOUNT SHOULD MY PAYMENT NOT BE RECEIVED ON THIME. THIS AUTHORIZATION WILL REMAIN IN PLACE FOR THE LIFE OF THE ANIMAL UNLESS REVOKED IN WRITING BY THE CLIENT.  SIGNATURE OF CLIENT: DATE:  DATE:  CO-OWNER SIGNATURE:  DATE:						
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(PLEASE READ CAREFULLY)  I CERTIFY THAT I OWN THE ABOVE DESCRIBED ANIMAL(S). I DO HEREBY AUTHORIZE VETERINARY HEALTHCARE CENTER AND ITS STAFF TO ADMINISTER VACCINATIONS, MEDICATIONS, TESTS, TREATMENTS, SURGICAL PROCEDURES, AND TO HOSPITALIZE MY PET IF THE DOCTORS DEEM IT NECESSARY FOR THE HEALTH, SAFETY, OR WELL-BEING OF THE ABOVE ANIMAL(S) WHILE THEY ARE UNDER THEIR CARE AND SUPERVISION. EXCEPT IN DIRE EMERGENCIES ALL TREATMENTS AND PROCEDURES WILL BE DISCUSSED WITH ME PRIOR TO IMPLEMENTATION. I UNDERSTAND THAT VETERINARY HEALTHCARE CENTER DOES NOT OFFER 24 HOUR DOCTOR CARE FOR THEIR PATIENTS AND THAT I MAY BE REQUIRED TO TRANSFER MY PET TO ANOTHER FACILITY IF AFTERHOURS CARE IS NECESSARY. I ALSO ACCEPT FULL FINANCIAL RESPONSIBILITY AND WILL PAY FOR ALL PROCEDURES AND TREATMENTS IN FULL AT THE TIME THE ANIMAL IS DISCHARGED. I UNDERSTAND THAT MY PERSONAL INFORMATION WILL NOT BE SHARED OR SOLD TO ANY THIRD PARTY AND WILL BE KEPT PRIVATE. LASTLY, I FURTHER AGREE THAT A FINANCE CHARGE OF 11/2% PER MONTH (18% PER ANNUAL) MINIMUM CHARGE, BUT NOT LIMITED TO \$5.00 SHALL BE ADDED TO MY ACCOUNT SHOULD MY PAYMENT NOT BE RECEIVED ON TIME. THIS AUTHORIZATION WILL REMAIN IN PLACE FOR THE LIFE OF THE ANIMAL UNLESS REVOKED IN WRITING BY THE CLIENT.  SIGNATURE OF CLIENT:  DATE:  CO-OWNER SIGNATURE:  DATE:	OTHER VACCINATIONS?					
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Co-Owner Signature: Date:	TO ADMINISTER VACCINATIONS, MOCTORS DEEM IT NECESSARY FOR CARE AND SUPERVISION. EXCEPT IMPLEMENTATION. I UNDERSTANI PATIENTS AND THAT I MAY BE REACCEPT FULL FINANCIAL RESPONDISCHARGED. I UNDERSTAND THE KEPT PRIVATE. LASTLY, I FURTHEIN NOT LIMITED TO \$5.00 SHARMAND STANDARD	DESCRIBED ANIMAL(S MEDICATIONS, TESTS, OR THE HEALTH, SAFI IN DIRE EMERGENCIE D THAT VETERINARY I QUIRED TO TRANSFER SIBILITY AND WILL PA AT MY PERSONAL INF R AGREE THAT A FINAL LL BE ADDED TO	S). I DO HEREBY AUTHORIS TREATMENTS, SURGICAL ETY, OR WELL-BEING OF TO SELL TREATMENTS AND INTERPORT OF THE PROCEDURES AND AUTHOR OF	ZE VETERINARY HEALTHON TO THE ABOVE ANIMAL(S) WE PROCEDURES WILL BE DOES NOT OFFER 24 HOLD ACILITY IF AFTERHOURS AND TREATMENTS IN FULL SHARED OR SOLD TO AMER MONTH (18% PER ANIMAL) MY PAYMENT NOT	HOSPITALIZE MY PET IF THE HILE THEY ARE UNDER THEIR ISCUSSED WITH ME PRIOR TO UR DOCTOR CARE FOR THEIR CARE IS NECESSARY. I ALSO LAT THE TIME THE ANIMAL IS NY THIRD PARTY AND WILL BE NUAL) MINIMUM CHARGE, BUT BE RECEIVED ON TIME.	
"	SIGNATURE OF CLIENT:			DATE:		
	Co-Owner Signature:		DATE: RECEPTIONIST'S INITIALS:			