

REDONDO SHORES VETERINARY CENTER
701 SOUTH PACIFIC COAST HIGHWAY
REDONDO BEACH, CA 90277
(310) 540-5588



WELCOME TO OUR HOSPITAL

THANK YOU FOR CHOOSING OUR HOSPITAL.
IN ORDER TO SERVE YOU PROPERLY, WE WILL NEED THE FOLLOWING INFORMATION. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

PET INFORMATION (ADDITIONAL PETS ON BACK)

PET'S NAME _____ BIRTH DATE OR AGE _____

CIRCLE ONE: DOG CAT OTHER _____ CHECK WHAT APPLIES: MALE FEMALE ALTERED?

BREED: _____ COLOR _____

NAME AND PHONE NUMBER (IF KNOWN) OF HOSPITAL WHERE LAST VACCINES WERE GIVEN: _____

DATE LAST VACCINATIONS WERE GIVEN:

CANINE: DA2PP _____ CORONA _____ BORDETELLA _____ RABIES _____

FELINE: FVRCP _____ FELV _____ FIP _____ RABIES _____

HOW LONG HAVE YOU HAD THIS PET? _____ WHAT DO YOU FEED YOUR PET? _____

IS YOUR PET ON ANY MEDICATIONS? IF SO, PLEASE LIST _____ ON ANY VITAMINS? _____

CLIENT INFORMATION

Mr. Ms. Mrs. Dr.

CLIENT NAME _____

LAST

FIRST

MIDDLE

HOME ADDRESS _____

STREET

CITY

STATE

ZIP CODE

HOME PHONE _____ E-MAIL _____

EMPLOYER _____ BUSINESS PHONE _____

SPOUSE/CO-OWNER _____ SPOUSE'S/CO-OWNER'S EMPLOYER _____

CELL PHONE _____ SPOUSE'S/CO-OWNER'S CELL PHONE _____ FAX NUMBER _____

For check writing privileges...

DRIVER'S LIC. / IDENTIFICATION # _____ SOCIAL SECURITY # _____

HOW DID YOU BECOME AWARE OF OUR HOSPITAL? _____ LOCATION _____ SBC YELLOW PAGES _____ VERIZON _____ OTHER (PLEASE INDICATE) _____

PERSONAL REFERRAL (IF SO, WHO MAY WE THANK?) _____

I UNDERSTAND THAT PAYMENT MUST BE MADE AT THE TIME SERVICES ARE RENDERED. A DEPOSIT MAY BE REQUIRED ON SURGICAL OR OTHER PROCEDURES. I AUTHORIZE TREATMENT FOR THE PATIENT(S) NAMED AND ACCEPT RESPONSIBILITY FOR THE CHARGES INCURRED IN THE ABOVE SAID HOSPITAL.

SIGNATURE

DATE

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