



CITY OF ANGELS
 Veterinary Specialty Center
 Come. Heal.

NEW CLIENT FORM

*Thank you for giving us the opportunity to care for your pet.
 So that we may become better acquainted, please complete the following:*

Owner's Name _____

Other Authorized Agent _____

Home Address _____ City _____ St _____ Zip _____

Home Phone # () _____ Cell/Pager # () _____

Best Number to Reach You () _____ Fax # () _____

Email Address _____

Drivers License Number _____ Social Security Number _____

Employer _____ Occupation _____

Address _____ Phone () _____

How did you hear about us? _____

PET INFORMATION

Please complete the following for the pet we are seeing today:

Name of Pet _____ Dog / Cat / Other Breed _____

Approximate Age _____ Sex _____ Spayed/Neutered _____

Color _____ Is your pet current on vaccinations? _____

Referring Doctor(s) _____

Hospital _____

Have you been to City of Angels before? _____ Which Practice? _____

What is the reason for your visit? _____

Known drug allergies: _____

Medications your pet is currently taking:

- YES. Please share my information with other City of Angels practices in the event that my pet may need their services.
- YES. I authorize and direct the veterinarians at City of Angels to diagnose, prescribe, perform therapeutic procedures, and/or surgery that their judgment may dictate to be advisable for the patients well being. No warranty or guarantee has been made as to the result or cure.

Client Signature _____ Date _____

