

*Bay Cities Veterinary Hospital
13476 Washington Blvd.
Marina del Rey, CA 90292-5626
310.821.4967 310.306.9785 fax*

NEW CLIENT/UPDATE FORM

DATE: _____

Title: (Please circle one): Mr. Mrs. Miss Ms. Dr.

NAME: _____

First MI Last

SPOUSE/OTHER RESPONSIBLE PARTY

First MI Last

ADDRESS: _____

ZIP CODE: _____ - _____ CITY: _____ STATE: _____

E-MAIL ADDRESS _____

HOME PHN: () _____ WORK PHN: () _____ EXT. _____

OTHER PHNS: () _____ EXT. _____ () _____

Referred by: (Circle One) GTE PACIFIC BELL OTHER _____

DRIVERS LIC. NUMBER: _____ STATE _____ BIRTH DATE: _____

(REQUIRED FOR CHECKS AND CREDIT CARD PAYMENTS)

EMPLOYER: _____

PET INFORMATION

NAME: _____ Species: Canine [] Feline []

BREED: _____ SEX: _____ SPAYED/NEUTERED: YES / NO

COLOR: _____ BIRTH DATE _____ WEIGHT _____

VACCINE INFORMATION (DATE LAST GIVEN)

CANINE

DHPP _____

RABIES _____

BORDETELLA _____

FELINE

FVRCP _____

RABIES _____

FELV _____

METHOD OF PAYMENT

PLEASE CHECK ONE: CASH [] CHECK * [] VISA/MASTERCARD * [] *CDL required

A DEPOSIT IS REQUIRED WHEN A PATIENT ENTERS THE HOSPITAL. BALANCE MUST BE PAID IN FULL WHEN YOUR ANIMAL IS RELEASED. PAYMENT IS DUE AS SERVICES ARE RENDERED. SORRY, NO OTHER ARRANGEMENTS CAN BE MADE. I ALSO AGREE TO PAY ANY COLLECTION/DEFAULT FEES. ON UNPAID BALANCES, THERE IS A \$ 5.00 FEE PER STATEMENT. AFTER 30 DAYS AN ADDITIONAL 19.8% IS CHARGED. RETURN CHECK FEE IS \$22.00. SUBJECT TO CHANGE.

SIGNATURE: _____ DATE: _____