Welcome to

Veterinary Medical Center, Studio City

We are glad to have the opportunity to care for your pet.
To ensure your pet receives the best care we can offer, please fill out this form completely.

Client Registration :

Client Name _____
Last First

Home Phone Number_____ Email_____

Additional Phone Numbers _____

Address_____
City State Zip

How to you prefer to be contacted ? Home Cell Work Fax Email

Employer _____Occupation_____

Address_____Phone_____
City State Zip

Preferred method of payment ? Cash Check Visa/Master/Discover/Amex Care Credit

Driver's License _____ Date of Birth_____ Social Security # _____

How did you hear about us? _____
(Person or Company)

Website Yellow pages Sign Other _____

I authorize the following individual(s) to make treatment decisions and or add patients to my file.

Spouse/Co Owner_____
Last First

Phone Numbers _____ Email_____

Additional Authorized Caregivers_____

Phone Numbers _____ Email_____

I hereby authorize Veterinary Medical Center, Studio City its employees and/or representatives to render medical and/or surgical care for my pet(s) as deemed necessary by the veterinarian. I understand that payment for treatment, diagnostic test and/or surgery preformed is required in full upon discharge and I accept full financial responsibility. I understand that continuous care may not be provided during some evening/ weekend/holiday hours. I authorize VMCSC to use photos of my pet(s) in ads/promotional items.

Signature_____Date_____

Patient Information:

Pets Name _____ Species_____Breed_____

Age/Date of Birth _____Color_____

Sex : Female Spayed Male Neutered

Microchip Information_____

Vaccine Information:

Canine		**Feline**	
DHPP-C		FVRCP	
Rabies		Rabies	
Bordetella		FeLV	
Heartworm Test		FIV	
Rattlesnake			