

**NORTHRIDGE VETERINARY CENTER**

**(818) 832-1888**

**Client Information Sheet**

Date: \_\_\_\_\_

**Client Information  
Guardian**

**Spouse/Additional**

Mr.  Mrs.  Ms.  Dr.

|                |       |   |       |
|----------------|-------|---|-------|
| Name(s)        | _____ | * | _____ |
| Home Address   | _____ | * | _____ |
| City/State/Zip | _____ | * | _____ |
| Occupation     | _____ | * | _____ |
| Home Telephone | _____ | * | _____ |
| Work Telephone | _____ | * | _____ |
| Mobile         | _____ | * | _____ |
| E-mail Address | _____ | * | _____ |
| Date of Birth  | _____ | * | _____ |

The State of California Department of Justice requires us to record your date of birth for Controlled Substance Utilization Review and Evaluation System (CURES). If you elect not to give us your date of birth, we cannot send home or prescribe controlled medications for your pet.

To prevent the spread of infectious disease, all boarders and grooming pets must be current on all recommended vaccines.

How did you hear about us (Website, Facebook, a friend, etc.)? \_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_ Breed: \_\_\_\_\_

Species:  Canine  Feline  Other: \_\_\_\_\_

Sex:  Male  Female  Neutered  Spayed

Birth date: \_\_\_\_\_

**PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED**

I understand that if I do not pay my balance in full the account will be subject to costs of collection and attorney fees. Return check fee is \$30. I understand that the hospital staff will provide an estimate of current and anticipated charges any time I request one. I am requesting that veterinary care be provided for pets presented by me or my agents. I understand that I am financially responsible for all services provided. By submitting this form I agree to the payment terms above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_