LARCHMONT ANIMAL CLINIC
CLIENT REGISTRATION FORM

316 N. LARCHMONT BLVD
LOS ANGELES, CA 90004 • 323-463-4889

CLIENT'S____
LAST NAME FIRST NAME SPOUSE'S FIRST NAME

ADDRESS____
NUMBER STREET CITY ZIP

CELL PHONE (______)____________________HOME PHONE (______)____________________ WORK (_____)____________________

OCCUPATION____________________BUSINESS ADDRESS____
NUMBER STREET CITY ZIP

EMAIL____REFERRED BY____________________

EMERGENCY CONTACT NAME____
PHONE

PET'S NAME____________________ Dog ☐ Cat☐ Other__________

BREED____________________COLOR____________________

Male or Female NEUTERED Y or N Birthdate/Age______________

DATE OF LAST VACCINES:

DHL-PP/CORONA (Dog)____________________

BORDETELLA (Dog)____________________

RABIES____________________

FVR-CP (Cat)____________________

LEUKEMIA (Cat)____________________

PET'S NAME____________________ Dog☐ Cat☐ Other__________

BREED____________________COLOR____________________

Male or Female NEUTERED Y or N Birthdate/Age______________

DATE OF LAST VACCINES:

DHL-PP/CORONA (Dog)____________________

BORDETELLA (Dog)____________________

RABIES____________________

FVR-CP (Cat)____________________

LEUKEMIA (Cat)____________________

PROFESSIONAL FEES ARE PAYABLE AT THE TIME OF SERVICES

Our financial policy requires payment at the time the service is rendered. We do not bill. We encourage you to discuss services before starting treatment. Upon request, a written estimate will be provided. A deposit maybe requested for some services.

All payment forms accepted with State ID. Returned checks are subject to a bank fee. ID is requested for your protection.

____Expiration Date______________Birthdate________________
Driver's License Number

Am/Ex DISC M/C VISA DEBIT Care Credit______________________________ Expiration Date______________

AUTHORIZATION FOR MEDICAL TREATMENT- PLEASE READ AND SIGN

I hereby authorize the veterinarians and staff of Larchmont Animal Clinic to administer such treatment as is considered therapeutically and/or diagnostically necessary. I also consent to the administration of such anesthetic as are necessary.

I understand no guarantee of successful treatment is made. I assume financial responsibility for all charges incurred to the patient and agree to pay all such charges at the time of treatment of release of patient.

I further understand that veterinary service is provided after hours, as necessary, in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided at all times.

SIGNATURE OF OWNER____DATE____________________

Person Presenting Animal IF NOT Owner______________________________Relationship________________

Non-Owner's Address____
Number Street City Zip Code

Phone (______)____________________Cell (______)____________________