California Veterinary Hospital

230 W Victoria Street
Gardena, CA 90248
310 323-6867 FAX 310 323-6870

NEW CLIENT FORM

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

Client ID # _____
OFFICE USE ONLY

CLIENT INFORMATION

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell Phone _____ Work Phone _____

Place Of Employment _____ Best Time To Reach You _____

Driver's License # _____ Social Security # _____ E-Mail Address _____

Birth date _____

In the event of an emergency where we are unable to contact you directly, whom may we contact as an alternate?

_____ _____ _____
Emergency Contact Name Relationship to Owner Contact Number

How did you become aware of our clinic? ☐ Drove by ☐ Shelter ☐ Previous Client *(Whom may we thank?)* _____

☐ Other _____

	Patient ID# _____	Patient ID# _____	Patient ID# _____
NAME			
BREED			
DATE OF BIRTH or AGE			
COLOR			
SEX; SPAYED OR NEUTERED?			
YOUR DOG'S VACCINATION HISTORY (please fill in date given):			
RABIES			
DHLP PARVO			
BORDETELLA			
CORONA			
GIARDIA			
LYME			
YOUR CAT'S VACCINATION HISTORY (please fill in date given):			
RABIES			
FVRCPC			
LEUKEMIA TEST			
FELV/FIV			
FECAL (STOOL SAMPLE)			

Our pet(s) is: ☐ Member of our family ☐ Child's pet ☐ Backyard pet ☐ Parent's pet

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

All Fees Are Due At The Time Services Are Rendered

Client Signature _____ **Date** _____