

# REGISTRATION FORM

Date \_\_\_\_\_

MONTECITO ANIMAL CLINIC  
5280 PACHECO BLVD  
PACHECO, CA 94553

PHONE: 925-686-0683  
FAX: 925-686-4754

**( PLEASE PRINT )**

NAME \_\_\_\_\_ HOME # \_\_\_\_\_  
First Last

ADDRESS \_\_\_\_\_  
Street City Zip

EMAIL \_\_\_\_\_

OCCUPATION \_\_\_\_\_ WORK # \_\_\_\_\_ Cell# \_\_\_\_\_

EMPLOYER \_\_\_\_\_  
Name Street City Zip

DRIVERS LICENSE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

SPOUSE/CO-OWNER \_\_\_\_\_ WORK # \_\_\_\_\_  
First Last

SPOUSE'S EMPLOYER \_\_\_\_\_  
Name Street City ZIP

DRIVERS LICENSE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

REFERRED BY \_\_\_\_\_

PREVIOUS VETERINARIAN(S) WHERE PAST RECORDS COULD BE OBTAINED IF NECESSARY

1 \_\_\_\_\_ PHONE \_\_\_\_\_

2 \_\_\_\_\_ PHONE \_\_\_\_\_

IN THE EVENT OF AN EMERGENCY WHERE I AM NOT AVAILABLE I AUTHORIZE THE FOLLOWING FRIENDS/FAMILY TO BRING IN MY PET(S) AND MAKE ANY NECESSARY DECISIONS REGARDING THEIR TREATMENT.

CONTACTS 1 NAME \_\_\_\_\_ PHONE# \_\_\_\_\_

2 NAME \_\_\_\_\_ PHONE# \_\_\_\_\_

**ANIMAL INFORMATION**

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5280 PACHECO BLVD  
PACHECO, CA. 94553

PHONE 925-686-0683  
FAX 925-686-4754  
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NAME OF PET \_\_\_\_\_ BIRTHDATE/ APROX AGE \_\_\_\_\_

BREED \_\_\_\_\_ COLOR \_\_\_\_\_

SEX MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ SPAY/NEUTERED \_\_\_\_\_

**MICROCHIP #:** \_\_\_\_\_

**VACCINATIONS :** ( PLEASE FILL IN THE DATE THEY WERE GIVEN )

**DOGS:**

RABIES \_\_\_\_\_

DHLPP \_\_\_\_\_

BORDATELLA \_\_\_\_\_

LYMES \_\_\_\_\_

CORONA \_\_\_\_\_

**CATS:**

RABIES \_\_\_\_\_

FVRCP \_\_\_\_\_

FELV \_\_\_\_\_

FIP \_\_\_\_\_

**TESTS:**

HEARTWORM \_\_\_\_\_

PARVO \_\_\_\_\_

FECAL \_\_\_\_\_

FELINE LEUKEMIA \_\_\_\_\_

DEWORMER \_\_\_\_\_

FELINE FIV \_\_\_\_\_

IS YOUR PET CURRENTLY TAKING ANY MEDICATIONS?  
\_\_\_\_\_

IS YOUR PET ALLERGIC TO ANY MEDICATIONS?  
\_\_\_\_\_

I AM THE LEGAL OWNER OR A REPRESENTATIVE FOR THE LEGAL OWNER OF THE ANIMAL BEING PRESENTED FOR TREATMENT, AND I AM OVER THE AGE OF 18

I HEREBY AUTHORIZE MONTECITO ANIMAL CLINIC TO EXAMINE, PRESCRIBE FOR OR TREAT THE ABOVE DESCRIBED PET I ASSUME RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF THIS ANIMAL I UNDERSTAND THAT THESE CHARGES WILL BE PAID AT THE TIME OF DISCHARGE FROM THE CLINIC OR WHEN SERVICES ARE OTHERWISE TERMINATED, AND THAT A DEPOSIT MAY BE REQUIRED FOR SURGICAL TREATMENT I ALSO UNDERSTAND THAT ALL MEDICAL RECORDS, INCLUDING RADIOGRAPHS, PERTAINING TO THE ABOVE ANIMAL BELONG TO AND ARE THE PROPERTY OF MONTECITO ANIMAL CLINIC

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_