

*Bay Cities Veterinary Hospital  
13476 Washington Blvd.  
Marina del Rey, CA 90292-5626  
310.821.4967 310.306.9785 fax*

**NEW CLIENT/UPDATE FORM**

DATE: \_\_\_\_\_

Title: (Please circle one): Mr. Mrs. Miss Ms. Dr.

NAME: \_\_\_\_\_

First MI Last

**SPOUSE/OTHER RESPONSIBLE PARTY**

\_\_\_\_\_  
First MI Last

ADDRESS: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_ - \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

HOME PHN: ( ) \_\_\_\_\_ WORK PHN: ( ) \_\_\_\_\_ EXT. \_\_\_\_\_

OTHER PHNS: ( ) \_\_\_\_\_ EXT. \_\_\_\_\_ ( ) \_\_\_\_\_

Referred by: (Circle One) GTE PACIFIC BELL OTHER \_\_\_\_\_

DRIVERS LIC. NUMBER: \_\_\_\_\_ STATE \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

(REQUIRED FOR CHECKS AND CREDIT CARD PAYMENTS)

EMPLOYER: \_\_\_\_\_

**PET INFORMATION**

NAME: \_\_\_\_\_ Species: Canine [ ] Feline [ ]

BREED: \_\_\_\_\_ SEX: \_\_\_\_\_ SPAYED/NEUTERED: YES / NO

COLOR: \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ WEIGHT \_\_\_\_\_

**VACCINE INFORMATION (DATE LAST GIVEN)**

CANINE

DHPP \_\_\_\_\_

RABIES \_\_\_\_\_

BORDETELLA \_\_\_\_\_

FELINE

FVRCP \_\_\_\_\_

RABIES \_\_\_\_\_

FELV \_\_\_\_\_

**METHOD OF PAYMENT**

PLEASE CHECK ONE: CASH [ ] CHECK \* [ ] VISA/MASTERCARD \* [ ] \*CDL required

**A DEPOSIT IS REQUIRED WHEN A PATIENT ENTERS THE HOSPITAL. BALANCE MUST BE PAID IN FULL WHEN YOUR ANIMAL IS RELEASED. PAYMENT IS DUE AS SERVICES ARE RENDERED. SORRY, NO OTHER ARRANGEMENTS CAN BE MADE. I ALSO AGREE TO PAY ANY COLLECTION/DEFAULT FEES. ON UNPAID BALANCES, THERE IS A \$ 5.00 FEE PER STATEMENT. AFTER 30 DAYS AN ADDITIONAL 19.8% IS CHARGED. RETURN CHECK FEE IS \$22.00. SUBJECT TO CHANGE.**

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