Downey Veterinary Hospital

11220 Brookshire Ave. | Downey, CA 90241 | Phone 562-923-0763 | Fax 562-923-3636

For Office Use Only
Account #

ACCURATE MEDICAL RECORDS ARE CRITICAL. PLEASE FILL OUT COMPLETELY.

**** OWNER MUST BE 18 YEARS OR OLDER ****
[Dr.] [Mr.] [Mrs.] [Ms.] [Miss] (Circle One)

Preferred Language: English [ ] Spanish [ ]
Pet Insurance: Yes [ ] No [ ]

OWNER'S LAST NAME_____ **FIRST NAME**_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____ HOME PH ( )_____

E-MAIL ADDRESS_____ CELL PH ( )_____

DATE OF BIRTH _____ DRIVER'S LIC # _____

SOCIAL SECURITY:**(required by law if a controlled substance is prescribed to your pet)** _____

EMPLOYER_____ WORK PHONE ( )_____

ADDITIONAL AUTHORIZED OWNERS/AGENTS: (Anyone you give authorization to make decisions regarding your pet's health. Must be over 18 years old.)

Name:_____ Phone #'s: _____

Spouse( ) Domestic Partner( ) Fiancé( ) Boyfriend/girlfriend( ) Roommate( ) Friend ( ) Parent( ) Family Member( )_____

Date of Birth _____ Driver's License # _____ Exp. Date: _____

Name:_____ Phone #'s: _____

Spouse( ) Domestic Partner( ) Fiancé( ) Boyfriend/girlfriend( ) Roommate( ) Friend ( ) Parent( ) Family Member( )_____

How were you referred to us? Internet _____ Sign _____ Friend _____ Phone Book(name) _____
If you were referred by a friend, please let us know their name; so that we can send a Thank You card.

Name_____ Pet's Name _____

By signing below, I understand and agree to the following policies:

- **ALL FEES ARE TO BE PAID at the time services** are rendered. We do not offer any form of billing or extend credit.
- There is a $35.00 Cancellation/Rescheduling fee for any procedure not cancelled/rescheduled
- **72 hours PRIOR** to scheduled procedure.
- A $25.00 late fee will be assessed each month for any outstanding balance 30 days past due. Accounts past due over 90 days will be subject to collections.
- A $50.00 fee will be charged for returned checks.
- For some treatments or hospitalized care, a deposit is required. Healthcare plans requiring comprehensive care of $200.00 or more, will require a minimum 50% deposit to begin your pet's treatment.

Signature _____ **Date** _____

PET INFORMATION:

Pet's Name _____

Date of Birth _____ Breed _____ Color _____

Sex: Female( ) Male( ) Neutered: Yes( ) No( )

Micro Chip# _____

Pet's Name _____

Date of Birth _____ Breed _____ Color _____

Sex: Female( ) Male( ) Neutered: Yes( ) No( )

Micro Chip# _____