# Lake Forest Animal Clinic
## Client Information

__Dr __Mr
__Mrs __Ms

**Last Name:** ________________________________ **First:**_____________________ **Spouse:**__________________

**Address:** ________________________________________________ **City:**__________________ **Zip:**__________

**Home Phone:** ___________________________________ **Cell Phone:** _____________________________________

**Email:** __________________________________________________________________________________________

**Occupation/Title:** ______________________________________ **Employer:** ________________________________

**Employer's Address:** __________________________________________ **Work #:** ___________________________

**Spouse's Occupation/Title:** ________________________________ **Employer:** ______________________________

**Employer's Address:** ____________________________________________**Work #:**___________________________

**Nearest Relative:** _______________________________________ **Phone Number:** ___________________________

**Have you had other pets treated here previously?** ____ **YES** ____ **NO** **Personal Referral:** ______________________________

**How did you hear of our office?**

____ **Yellow Pages** ____ **Clinic Sign** ____ **Advertisement** ____ **Animal Shelter** ____ **Letter**

____**Internet (Google/Bing/FaceBook/Yelp/CitySearch/Website)**

**I understand that professional fees are to be paid at the time services are rendered and that deposits are required on all hospitalized patients. Cash, Check, Visa, MasterCard and American Express are accepted for your convenience. There will be a $25.00 service charge imposed for all returned checks. If your check is returned, you could be liable for three times the amount of the check or $100.00, whichever is greater, in addition to the face value of the check, court costs and fees.**

**By signing below, you are hereby agreeing to pay all collection fees, attorney's fees and costs in the event of collection or legal action to enforce payment of monies due. A late charge will be imposed on all accounts over 30 days at 1 ½% per month or 18% per annum.**

**I AGREE AND CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.**

_______________________________________________________________ ________________________

**Owner's Signature** **Date**

***AUTHORIZATION TO DISCLOSE***

***By signing below, I authorize Lake Forest Animal Clinic to disclose my contact information, including but not limited to, my name and address, and information about my pet, including its name, breed, size, color, and other identifying markers to third parties for the purpose of providing vaccine reminders, releasing medical records to requesting veterinarians, providing appointment reminders, issuing product recalls, providing wellness or other veterinary health care information or other special veterinary information that may be of interest to pet owners.***

***This Authorization to Disclose is intended as my written authorization pursuant to California Business and Professions Code section 4857 is limited to the items listed above and does not authorize disclosure of my pet(s)' medical records beyond what is specifically authorized pursuant to section 4857.***

***Signature:*** _______________________________***Date:***____________

# PLEASE SEE BACKSIDE

FOR OFFICE USE ONLY:
Date ________

Int _________