FIRE MOUNTAIN

VETERINARY HOSPITAL

(760) 757-7557
613 Crouch Street
Oceanside CA 92054
www.firemtvet.com

New Client Information

Last name: _____ First name: _____

Address: _____ Apt. _____ Home phone: _____

City: _____ State_____ Zip_____ Cell #: _____

Email: _____ Your date of birth (*) _____

*** This information is required by law for certain medications to be prescribed for your pet**.

Pet Name	Male/Female	Spayed/Neutered	Birthday/Age	Breed	Color

Animal Hospital where vaccines and any previous treatments have been performed:

Clinic Name & Phone number:_____

ALL FEES ARE DUE AND PAYABLE UPON COMPLETION OF SERVICE.

SORRY, WE DO NOT ACCEPT CHECKS!

I understand that every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed above. Furthermore, I agree to pay fees for all services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection, attorney fees and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the hospital is located. I understand that veterinary service is provided during nighttime hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided. I am at least 18 years of age and legally liable for any decisions I make.

Signature: _____Date: _____