PRINT EMAIL FORM

Bloomfield Animal Hospital
20927 Norwalk Blvd.
Lakewood, CA 90715
(562) 402-9717

Please fill out the following:

Owner's Name		Spouse/ Partner	
Cell Phone		Alternate Phone	
Home address			
City		State/ zip code	
Driver's License #		Spouse/Partner Phone	
Email			
Employer		Work Phone	

Would you prefer to receive text or calls for some reminders for your pet? Text or Call (Please Circle One)

How did you hear about us? Please mark one	Clinic Sign ☐	Facebook ☐	Google ☐	AAHA ☐
	Yelp ☐	Web Site ☐	Newspaper ☐	Shelter ☐
	Referral ☐	Who may we thank?		

Do you give us permission to release your pets' vaccine records to other hospitals, boarding facilities and/or grooming shops when they are requested by them? (**Yes or No**) Yes **Initials:** _____

Will you allow us to post your pets' picture on our social media sites? We will never publish any of your personal information or any medical problems your pet may be having. (**Yes or No**) Yes **Initials:** _____

Do you have pet insurance? (**Yes or No**) _ Yes __ If yes, what company? _____

Pet Name	Dog/Cat	Breed	Birthday	Sex/ altered?	Vaccines Current	Is your pet microchipped	Is your pet on any medications

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I, the undersigned legal owner of the above-described pet(s), certify I am eighteen (18) years of age or older, and hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges in the care of this animal. No warranty or guarantee has been made as to the result or cure.

ALL FEES ARE REQUIRED TO BE PAID IN FULL UPON COMPLETION OF THE VISIT.

In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all cost included in said unpaid balance, including a collection and/or attorney's fees.

Owner Signature: _____ Date: _____