



Pacific Veterinary Specialists & Emergency Service

Welcome

1980 41st Avenue Capitola, CA 95010
Ph. 831-476-2584 ~ Fx. 831-476-8499
www.pvses.com

Date: _____
Time: _____
Client ID: _____

Thank you for giving us the opportunity to care for your pet. To ensure the best care possible, please take the time to fill in this form completely. Thank you.

Owner Name #1: _____ Name #2: _____
(circle preferred phone) (circle preferred phone)

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Employer: _____ Employer: _____

Work Phone: _____ Work Phone: _____

Driver's License #: _____ Driver's License #: _____

Owner's Birthdate: _____ Owner's Birthdate: _____

Street Address: _____ City, State & Zip: _____

Mailing Address: _____ City, State & Zip: _____

Alternate Contact Name & Phone: _____

Referring or Regular Veterinarian: _____ Pharmacy of
Choice: _____

Reason for today's visit: _____

Pet's Name: _____ Dog ___ Cat ___ Other _____ Birthdate/Age: _____

Breed: _____ Color: _____ Male ___ Neutered ___ Female ___ Spayed _____

I hereby authorize the veterinarian to examine, prescribe for or treat the described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of service and that a deposit will be required for treatment. Unpaid invoices may be subject to finance charges. There will be a fee for all returned checks. We reserve the right to refuse service at our own discretion, exclusive of life-stabilizing measures.

Signature of Owner: _____ Date: _____

We gladly accept: American Express, Visa, Mastercard, Cash, Checks and Care Credit