# Calaveras Veterinary Clinic

140 West Calaveras Boulevard
Milpitas, California 95035
(408)-262-7200

Thank you for trusting us with your pet's health. Please take a moment to tell us about yourself and your pet(s).

Mr. / Ms. / Mrs. Owner(s) _____ Home Phone _____

Address _____ City _____ Zip _____

May we contact you at work? Yes/No Work Phone _____

Email _____ Cell Phone _____

**Please list other people authorized for pet to be released to or obtain information on your behalf.**

Contact _____ Relation _____ Phone _____

Contact _____ Relation _____ Phone _____

**Preferred Contact Method**: ☐ Cell Phone ☐ Home Phone ☐ Email ☐ Text Message

**How did you become aware of our clinic? _____**

**PATIENT INFORMATION** (Please fill in the following for each pet)

| | Pet 1 | Pet 2 | Pet 3 |
|---|---|---|---|
| Name | | | |
| Species (Cat/Dog) | | | |
| Breed | | | |
| Color | | | |
| Date of Birth (Age) | | | |
| Sex | | | |
| Spay/Neuter | | | |

**I authorize Calaveras Veterinary Clinic to use my pet's likeness for marketing purposes, including but not limited to use on their website or Facebook page. I grant Calaveras Veterinary Clinic permission to take and/or use any photographs of my pet(s) for their publications. Yes____ No____**

**I hereby authorize Calaveras Veterinary Clinic and its veterinarians to examine, prescribe for, and treat the above described pet(s). I release Calaveras Veterinary Clinic and its veterinarians from any liability related to any such care. I assume full responsibility for all charges incurred and I understand that a deposit may be required for hospitalization and/or treatment. I understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED and agree to pay for services.**

**Note: Staff will not be present in hospital premises between 6 p.m. to 7:30 a.m.**

**Signature of Owner or Responsible Party** _____ **Date** _____

If you plan to pay by check please complete the following:
Driver's License Number _____ Exp. Date _____