



# CALABASAS ANIMAL CLINIC

4937 Las Virgenes Road  
Suite 101, Calabasas, CA 91302  
Phone: (818) 880-0888  
Fax: (818) 880-1063  
**New Client Form**

Thank you for allowing the staff at Calabasas Animal Clinic the opportunity to care for your pet.  
Please complete the following information to better help us serve you:

NAME \_\_\_\_\_ SPOUSE \_\_\_\_\_ DATE \_\_\_\_\_  
LAST FIRST

ADDRESS \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE

EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE

PHONE: Home (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_-\_\_\_\_

EMAIL: \_\_\_\_\_

Would you like to receive your pet(s) health information by e-mail? Yes No

How did you select us to be your pet(s) health care facility? (i.e. internet, yellow pages, sign, referall, etc.)

\_\_\_\_\_

If referred, whom should we thank? \_\_\_\_\_

Previous Veterinarian/Clinic: \_\_\_\_\_

Do you have any special concerns about your pet(s) that we should be aware of and/or allergies we should know about? \_\_\_\_\_

	NAME	SPECIES	BREED	COLOR	DATE OF BIRTH	SEX (M/F)	Spay/Neuter (Y/N)
1.							
2.							
3.							
4.							
5.							

**Fees are to be paid at the time services are rendered. We do not have staff on premises overnight.**

Signature \_\_\_\_\_ Date \_\_\_\_\_