



OCEAN ANIMAL CLINIC AND THE CAT CLINIC OF SANTA CRUZ

404 OCEAN ST · SANTA CRUZ · 831.429.5100



SMALL ANIMAL, BIRD, AND EXOTIC PET CARE
 MEDICINE · SURGERY · DENTISTRY

TODAY'S DATE: _____

OWNER'S NAME: _____ HOME PHONE: _____
LAST NAME FIRST NAME M.I.

DATE OF BIRTH: _____ DRIVER LICENSE: _____ EXP: _____ CELL PHONE: _____

HOME ADDRESS: _____
NUMBER STREET APT # CITY STATE ZIP

E-MAIL ADDRESS: _____

EMPLOYER: _____ TITLE: _____ WORK PHONE: _____

CO-OWNER: _____ RELATION TO YOU: _____ CELL PHONE: _____
LAST NAME FIRST NAME

CO-OWNER'S EMPLOYER: _____ WORK PHONE: _____

HOW DID YOU HEAR ABOUT OUR HOSPITAL? HOSPITAL SIGN YELP GOOGLE FACEBOOK
 OTHER _____ PERSONAL REFERRAL _____

I GRANT OCEAN ANIMAL CLINIC PERMISSION TO POST MY PET'S PICTURE AND STORY ON SOCIAL MEDIA YES NO

	PET 1	PET 2
PET'S NAME		
SPECIES (DOG, CAT, BIRD, ETC)		
BREED		
COLOR		
BIRTH DATE / AGE		
MALE / FEMALE		
NEUTERED / SPAYED		
LAST VACCINATION DATE		
CURRENT MEDICATIONS?		
KNOWN ALLERGIES?		
PAST ILLNESSES?		

DO YOU HAVE RECORDS AT ANOTHER HOSPITAL? YES NO NAME OF HOSPITAL/DOCTOR: _____

AUTHORIZATION

I HEREBY AUTHORIZE THE DOCTORS OF THE OCEAN ANIMAL CLINIC / CAT CLINIC OF SANTA CRUZ TO EXAMINE, PRESCRIBE, AND/OR PERFORM ANY NECESSARY PROCEDURES, ANESTHESIA, OR SURGERY ON THE ABOVE MENTIONED PET. I AGREE TO PAY FOR ALL FEES AND MEDICATIONS AT THE TIMES THE SERVICES ARE RENDERED, OR BEFORE DISCHARGE OF A HOSPITALIZED PET. I UNDERSTAND THAT VETERINARY SERVICE DURING NIGHTTIME HOURS AND/OR WEEKENDS IS PROVIDED AT THE DISCRETION OF THE VETERINARIAN IN CHARGE. CONTINUOUS PRESENCE OF PERSONNEL MAY NOT BE PROVIDED DURING THESE HOURS.

SIGNATURE OF CLIENT RESPONSIBLE FOR PET(S): _____ DATE: _____

FOR OFFICE USE ONLY	COMP:	16	17	18	19	20	21	22	CLIENT ID NUMBER:
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