Shadow Hills Pet Clinic

SATISH K. MOHAN, D.V. M.
11814 SHELDON ST.
SUN VALLEY, CA 91352
(818) 767-3904

CLIENT INFORMATION

OWNER'S NAME AND ADDRESS	MR. MRS. MISS DR.			
	Last	First	Middle	Home Phone
	Street	Apt#	City	State / Zip
EMPLOYER'S NAME AND ADDRESS	SO THAT WE MAY CONTACT YOU IN CASE OF AN EMERGENCY:			
	Name	Business Phone		E-mail
	Street	City	State	Zip
SPOUSE				
	Name	Employer		

Usual Method of Payment

CASH ☐ CHECK ☐ MASTERCHARGE ☐ VISA ☐

DRIVER'S LICENSE# _____ DATE OF BIRTH _____

ANIMAL INFORMATION

DOG	CAT	Other	Name	Breed	Description	Age	Sex	Altered	Wt.	Dogs DHL	Rabies Dogs/Cats	FVRCP Cats	Heartworm Test	Leukemia

Charges are made for services rendered and payment for such charges is due at the time they are rendered, or prior to discharge of the animal from the hospital.

Any animal not picked up within the time required by Section 1834 of the California Civil Code shall be deemed abandoned by the owner and will be disposed of according to Section 1834.5 and 1834.6 of the California Civil Code.

VETERINARY SERVICE is provided during nightime hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided.

How did you hear about us?

Referred by _____

Clinic Signs ___ **Word of mouth** ___

Yellow Pages ___ **Other** _____

Cell Phone _____

_____
SIGNATURE

Shadow Hills Pet Clinic

S.K. Mohan D.V.M.

Authorization for Professional Services/ Hospitalization

Owner:_____ Pets Name: _____

As owner, or duly authorized agent of the owner, I hereby consent and authorize the staff of Shadow Hills Pet Clinic to hospitalize this animal, and to care for, administer vaccinations, medications, treatment and/or anesthetic as you deem advisable in the performance of surgical or therapeutic procedures you determine to be indicated for the health, safety or well being of the above described animal.

The nature of services has been described to me to my satisfaction and I realize that no guarantee nor warranty can ethically, professionally be made regarding the results or cure. I understand that Shadow Hills Pet Clinic assumes no responsibility for the actions of the animal under the owners care after he or she leaves the hospital.

I understand that I assume financial responsibility for all services rendered, and that payment is due at the time they are rendered or at the time the animal is discharged.

If this animal should injure itself in an escape attempt, refuse food, soil itself, become ill or die while in the hospital, I will hold the Shadow Hills Pet Clinic free of any responsibility and or/ liability in the absence of gross negligence.

Veterinary Services is provided during nighttime hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided.

OWNER/AGENTS SIGNATURE: _____

DATE: _____

HOMEPHONE: _____ CELL PH. /PAGER #: _____