Magalia Pet Hospital

Client Information

(PLEASE PRINT CLEARLY)

Primary Owner:_____

Secondary Owner:_____

Address:_____
Street Apartment/Unit #

_____
City State Zip code

Phone: ( )_____ cell/home/work _____
Name

Phone: ( )_____ cell/home/work_____
Name

Email:_____ *Client DOB:___/___/____
Month/day/year

How did you hear about us? _____

How many pets do you have? Dogs:_____ Cats:_____ Other:_____

Is there anyone else authorized to bring your pet in for appointments? Yes/No

Alternate Contact Name:_____ Phone: ( )_____

Relationship to client(s):_____

Payment is required at time of service. Balance due shall be paid by the person attending the appointment unless prior arrangements have been made (We accept the following payment options: Cash, Check, Credit Card, Care Credit and Scratch Pay.)

X_____ Date:_____
Signature

Would you like access to the Pet Portal? No/Yes (if yes complete the following)

Please choose an Email:_____ Password:_____
Must be 8 characters (1 upper case, 1 number)

*You will be required to have your date of birth on file for security verification purposes. Please make sure you fill that out in the above section. Thank you, please enjoy access to your pet's medical information.