Account #_____ (for office use)

2501 Village Lane, Cambria 805.927.7000

Thanks for entrusting us with your pet's care. Please tell us about yourself…

YOUR NAME: _____

YOUR MAILING ADDRESS: _____

_____

YOUR HOME PHONE NUMBER: _____

YOUR CELL PHONE / WORK PHONE: _____

YOUR EMAIL ADDRESS: _____

YOUR DATE OF BIRTH (for dispensing controlled medications): ____ / ____ / _____

HOW DID YOU HEAR ABOUT US?_____

Payment is due at the time services are rendered. We accept payment by cash, personal check, Mastercard, Visa, or CareCredit. We are happy to provide you with a written estimate of all costs prior to rendering any services. Initials: _____

Prescription refill requests require a minimum of 24 hours advance notice. Initials: _____

I authorize CAMC to use pictures of my pet(s) on social media sites / promotional materials. YES NO

We cannot release any information about your pets without your written authorization. I authorize CAMC to request/receive/release my pet's medical records to / from other veterinarian(s), as requested for their care and treatment. YES NO

My signature below acknowledges my understanding of and agreement to these policies.

Signature_____ Date_____