



# Canyon Creek Pet Hospital

5617 Silver Creek Valley Rd  
San Jose, CA 95138

## WELCOME

Thank you for giving CANYON CREEK PET HOSPITAL the opportunity to care for your pet. So we may become better acquainted, please complete the following:

Mr. / Ms. / Mrs. Owner(s) \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Please list other people authorized for pet to be released to or obtain information on your behalf.**

Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

**Preferred Contact Method:**  Cell Phone  Home Phone  Email  Text Message

**How did you become aware of our clinic?**

Yelp  Google Ads  Coupon Mailer  Walk-in

The Animal Clinic  Employee  Other  Referred by \_\_\_\_\_

### PATIENT INFORMATION (Please fill in the following for each pet)

	Pet 1	Pet 2	Pet 3
Name			
Species (Cat, Dog)			
Breed			
Color			
Date of Birth (Age)			
Sex			
Spay/Neuter			

#### Photo Consent

I hereby grant Canyon Creek Pet Hospital permission to take and/or use any photographs or other imaging of my pet(s), for their publications and social media. I understand and agree that these materials are the property of Canyon Creek Pet Hospital. I hereby authorize Canyon Creek Pet Hospital to edit, alter, copy, exhibit, publish or distribute photos for the purposes of publicizing their programs or for any other lawful purpose. I hereby release Canyon Creek Pet Hospital from all claims, demands, and causes to action which I or any other persons acting on my behalf have or may have, by reason of this authorization.  Yes  No

**I assume all responsibility for all charges incurred in the care of these pets. I understand that these charges will be paid at the time of release and a deposit may be required for surgical treatments and hospitalization.**

Signature of Owner or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Owner Date of Birth (This information is required for controlled substances) \_\_\_\_\_

If you plan to pay by check please complete the following:

Driver's License Number \_\_\_\_\_ Exp. Date \_\_\_\_\_