

NEW CLIENT FORM

*Thank you for giving us the opportunity to care for your pet(s).
 So that we may become better acquainted, please complete the following:*

CLIENT INFORMATION Date _____

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Work Phone _____ Cell Phone _____

Best Time To Reach You _____ Spouse's Work Phone _____

Place of Employment _____ Driver's License # _____

E-Mail Address _____ Would you prefer us to send reminders by: Mail : Email

I agree to pay for all of the medical services at the time they are rendered

Signature _____

Please indicate choice of payment. Cash / Check Visa MasterCard Discover Card

How did you become aware of our clinic? Drove by Yellow Pages Previous Client Web
 Personal Recommendation (*Whom may we thank?*) _____ Other

	PET # 1	PET # 2	PET # 3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX; SPAYED OR NEUTERED?			
YOUR DOG'S VACCINATION HISTORY:			
RABIES			
DHLP PARVO			
BORDETELLA			
INTRA TRAC II			
FECAL (STOOL SAMPLE)			
HEARTWORM TEST/PREVENTION?			
YOUR CAT'S VACCINATION HISTORY:			
RABIES			
DISTEMPER-RHINO CHLAMYDIA (FVRCP)			
LEUKEMIA TEST			
LEUKEMIA VACCINE			
FECAL (STOOL SAMPLE)			

Our pet(s) is: Member of our family Child's pet Backyard pet

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

Would you like to be present during treatment to your pet? Yes No