

## 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 \_\_\_\_\_ Spouse's Work Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Best time to Reach You \_\_\_\_\_

Driver's License # \_\_\_\_\_ E-Mail Address \_\_\_\_\_

**ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED**

**PLEASE INDICATE CHOICE OF PAYMENT: CASH CHECK VISA MC DISCOVER**

**How did you become aware of our clinic?    \_\_\_ Drove By    \_\_\_ Yellow Pages    \_\_\_ Other Client    \_\_\_ Advertisement**

**Personal Recommendation (Whom may we thank?)** \_\_\_\_\_

**PATIENT INFORMATION**

	<b>PET #1</b>	<b>PET #2</b>	<b>PET #3</b>
<b>NAME</b>			
<b>BREED</b>			
<b>DATE OF BIRTH</b>			
<b>COLOR</b>			
<b>SEX: Spay/Neuter</b>			
<b>Your pet's past veterinarian</b>			

Our pet(s) is:    \_\_\_ Member of the Family    \_\_\_ Child's Pet    \_\_\_ Backyard Pet

Any previous serious illnesses or surgeries? \_\_\_\_\_

Any allergies to vaccination or medications? \_\_\_\_\_

Is your pet on any special diets or medications? \_\_\_\_\_

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