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**_____

Owner Name_____ Spouse's Name_____

Address_____ City_____ State_____ Zip_____

Phone_____ Work Phone_____ Spouse's Work Phone_____ Cell_____

Place of Employment_____ Best Time To Reach You_____

E-mail Address_____

How did you become aware of our clinic? ☐ Sign/Location ☐ Yellow Pages ☐ Previous Client or

☐ Personal Recommendation (Whom may we thank?) _____

All Fees Are Due At The Time Services Are Rendered

Please indicate choice of payment, ☐ Cash/Check ☐ Visa/Mastercard ☐ American Express ☐ Discover

☛ **<u>These Fields Are Required</u>: Driver's License #**_____ **Date of Birth**_____

PET INFORMATION	PET #1	PET #2	PET #3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX: SPAYED OR NEUTERED?			
YOUR DOG'S VACCINATION HISTORY, NAME OF VETERINARIAN WHERE GIVEN			
RABIES DATE:			
DHLP PARVO CORONA DATE:			
BORDETELLA DATE:			
INTRA TRAC 11 DATE:			
FECAL (STOOL SAMPLE) DATE AND RESULT:			
HEARTWORM TEST DATE AND RESULT:			
YOUR CAT'S VACCINATION HISTORY, NAME OF VETERINARIAN WHERE GIVEN			
RABIES DATE:			
DIST-RHINO CHLAMYDIA DATE:			
LEUKEMIA TEST DATE:			
LEUKOCELL DATE:			
FECAL (STOOL SAMPLE) DATE AND RESULT:			

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? _____

Would you like to be present during treatment? _____