

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 # _____ D.O.B. _____ Signature _____

All Fees Are Due At The Time Services Are Rendered

Please indicate choice of payment. Cash/Check VISA MasterCard

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

	Pet #1	Pet #2	Pet #3
Name			
Breed			
Date of Birth			
Color			
Sex; Spayed or Neutered?			

YOUR DOG'S VACCINATION HISTORY:

Rabies			
DHLP Parvo Corona			
Bordetella			
Intra Trac II			
Fecal (Stool Sample)			
Heartworm Test/Prevention?			

YOUR CAT'S VACCINATION HISTORY:

Rabies			
Dist-Rhino Chlamydia			
Leukemia Test			
Leucocell			
Fecal (Stool Sample))			

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

Any previous serious illness or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets of medications? _____

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

Revised: _____ 200__ / _____ 200__ / _____ 200__