NEW CLIENT INFORMATION FORM

Date:

Owner’s Name:

Owner’s Address:
Street 1:
Street 2:
City:
State:
Zip:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Employer:

How did you become aware of us?

Pet’s Name:

Pet’s Breed:

Pet’s Color:

Pet’s Date Of Birth:

Date Of Most Recent Vaccinations:

Previous Clinic’s Name:

Previous Clinic’s Address:
Street 1:
Street 2:
City:
State:
Zip:

May we contact your previous veterinarian for a records transfer?
Yes
No

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

BOARDING REGISTRATION FORM

Drop-Off Date Requested:

Pick-Up Date Requested:

Owner’s Name:

Owner’s Phone Number

Street 1:

Street 2:

Owner’s Address:

City:

State:

Zip:

All Boarders MUST Have Up-To-Date Bordatella (Kennel Cough), Distemper Combo, and Rabies Vaccinations!

Pet’s Name:

Emergency Contact Name:

Emergency Contact Phone Number:

List your pet’s belongings:

DROP-OFF RELEASE FORM

Today’s Date:

Owner’s Name:

Owner’s Phone Number:

Street 1:

Street 2:

Owner’s Address:

City:

State:

Zip:

Pet’s Name:

Reason For Visit:

Will Your Pet Be Fed Prior To Arrival?

Yes

No

Is Your Pet On Heartworm Prevention?

Yes

No

If You Answered "Yes" To The Previous Question And You Would Like To Refill Your Pet’s Heartworm Medication, Then

| | |
|---|---|
| Please Specify The Name Of The Desired Medication: | |
| Is Your Pet On Flea Prevention? | Yes<br>No |
| If You Answered "Yes" To The Previous Question And You Would Like To Refill Your Pet’s Flea Prevention Medication, Then Please Specify The Name Of The Desired Medication: | |
| Has Your Pet Been Checked For Intestinal Parasites In The Last 6 Months? | Yes<br>No |
| Has Your Pet Ever Had Any Reaction To Medications? | Yes<br>No |
| Has Your Pet Ever Had Any Reaction To Vaccines? | Yes<br>No |
| Has Your Pet Ever Had Any Reaction To Anesthesia? | Yes<br>No |
| Is Your Pet Currently On Any Medication(s)? | Yes<br>No |
| If "Yes", Please List The Name Of The Medication And The Dosage: | |

HAS YOUR PET SHOWN ANY SIGN OF THE FOLLOWING?:

| | |
|---|---|
| Vomiting? | Yes<br>No |
| Diarrhea? | Yes<br>No |
| Listless? | Yes<br>No |
| No Appetite? | Yes<br>No |

| | |
|---|---|
| Weakness? | Yes<br>No |
| Coughing? | Yes<br>No |
| Gagging? | Yes<br>No |
| Scratching? | Yes<br>No |
| Shaking Head? | Yes<br>No |
| Scooting? | Yes<br>No |
| Seizures? | Yes<br>No |
| Abnormal Amount Of Urination? | Yes<br>No |
| Abnorma Amount Of Drinking? | Yes<br>No |
| Limping? | Yes<br>No |
| Abnormal Weight Loss Or Gain? | Yes<br>No |
| Unusual Lumps Or Bumps? | Yes<br>No |

TESTS & SERVICES TO BE PERFORMED DURING THIS VISIT:

Puppy/Kitten Wellness Exam

Annual Wellness Exam

Intestinal Parasite Exam

Deworm (If Needed)

Heartworm Test

FELV Test

FIV Test

Bath

Dip

Grooming

Other (Please Specify):

May We Sedate/Anesthesize Your Pet If Necessary? Yes No

By Clicking The "Submit" Button, I Agree With All Of The Following:The practice is to use all reasonable precaution against injury, escape, or death of my pet. The practice and staff WILL NOT be held liable for any problems that develop provided reasonable care and precautions are followed. I understand that ANY problem that develops with my pet while I'm absent will be treated as deemed best by the staff veterinarians and I ASSUME FULL RESPONSIBILITY for the treatment expense involved. I agree to pay fees for all services rendered at the time my pet is discharged from the practice or the service is otherwise terminated. I agree to pay for the reasonable costs of collection, attorneys fees and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the practice is located. If I neglect to pick up my pet within 7 days of the date below and do not notify the practice within that time frame, the practice may assume that the pet is abandoned and is hereby authorized to dispose of the pet as deemed best and/or necessary.

Client Name:

Client Phone Number:

Alternative Phone Number:

Client E-mail Address:

Pet's Name:

Name Of Medication To Be Refilled:

Quantity To Be Refilled:

Current Dosage Given:

Any Side Effects Seen? Yes No

Date Of Pet's Most Recent Exam:

Additional Comments:

We Will Contact You After Your Request Has Been Reviewed By A Doctor.

Please Allow 24 To 48 Hours For Processing Of Your Request.

CLIENT SATISFACTION SURVEY

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor

Professionalism Of Our Staff:

Cleanliness Of Our Facility:

Quality Of Services Received:

Overall Impression Of Our Practice:

Did You Have To Wait Past Your Scheduled Appointment Time?

Yes

No

If You Answered "Yes" To The Previous Question, Then Please Tell Us How Long You Had To Wait For Your Appointment:

Please Feel Free To Leave Us Any Additonal Comments:

NEW CLIENT INFORMATION FORM

Date:

Owner’s Name:

Owner’s Address:

Street 1:

Street 2:

City:

State:

Zip:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Email address:

Employer:

How did you become aware of us?

Pet’s Name:

Pet’s Breed:

Pet’s Color:

Pet’s Sex:

Male

Female

Neutered Male

Spayed Female

Pet’s Date Of Birth:

Date Of Most Recent Vaccinations:

Previous Clinic’s Name:

Previous Clinic’s Address:

Street 1:

Street 2:

City:

State:

Zip:

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Client Name:

Client Name:

Client Phone Number:

Alternative Phone Number:

Client E-mail Address:

Pet’s Name:

Name Of Medication To Be Refilled:

Quantity To Be Refilled:

Current Dosage Given:

Any Side Effects Seen?

Yes

No

Date Of Pet’s Most Recent Exam:

Additional Comments:

We Will Contact You After Your Request Has Been Reviewed By A Doctor.

Please Allow 24 To 48 Hours For Processing Of Your Request.

GROOMING REGISTRATION FORM

Requested Grooming Date:

Owner’s Name:

What Number Can We Reach You At Today?:

Owner’s Address:

Street 1:

Street 2:

City:

State:

Zip:

Are You A New Grooming Client?

Yes

No

option1

option2

Do You Have A Preferred Groomer?

Yes

No

If "Yes", Please Specify Preferred Groomer:

What Is Your Pet’s Name?:

Please List Any Special Instructions Regarding Grooming:

By Clicking The "Submit" Button, I Certify That I Understand All Of The Following: All fees are due and payable upon completion of services. Please allow 24 to 48 hours to process your request.

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor

Professionalism Of Our Staff:

Cleanliness Of Our Facility:

Quality Of Services Received:

Overall Impression Of Our Practice:

Did You Have To Wait Past Your Scheduled Appointment Time?

Yes

No

If You Answered "Yes" To The Previous Question, Then Please Tell Us How Long You Had To Wait For Your Appointment:

Please Feel Free To Leave Us Any Additonal Comments:

NEW CLIENT INFORMATION FORM

Date:

Owner’s Name:

New Address

Street 1:

Street 2:

City:

State:

Zip:

Owner’s Email Address:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Employer:

Driver’s License Number:

Pet’s Name:

Pet’s Breed:

Pet’s Color:

Pet’s Sex:

Pet’s Date Of Birth:

Date Of Most Recent Vaccinations:

Previous Clinic’s Name:

Previous Clinic’s Address:

Street 1:

Street 2:

City:

State:

| | |
|---|---|
| | Zip: |

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

DROP-OFF RELEASE FORM

| | |
|---|---|
| Today’s Date: | |
| Owner’s Name: | |
| Owner’s Phone Number: | |
| Owner’s Address: | Street 1:<br>Street 2:<br>City:<br>State:<br>Zip: |
| Owner’s Email Address | |
| Pet’s Name: | |
| Reason For Visit: | |
| Will Your Pet Be Fed Prior To Arrival? | Yes<br>No |
| Is Your Pet On Heartworm Prevention? | Yes<br>No |
| If You Answered "Yes" To The Previous Question And You Would Like To Refill Your Pet’s Heartworm Medication, Then Please Specify The Name Of The Desired Medication: | |
| Is Your Pet On Flea Prevention? | Yes<br>No<br>Yes<br>No<br>Not Applicable<br>option1<br>option2 |
| If You Answered "Yes" To The Previous Question | |

| | |
|---|---|
| And You Would Like To Refill Your Pet's Flea Prevention Medication, Then Please Specify The Name Of The Desired Medication: | |
| | Yes |
| | No |
| Has Your Pet Been Checked For Intestinal Parasites In The Last 6 Months? | option1 |
| | option2 |
| | option1 |
| | option2 |
| | option1 |
| | option2 |
| Has Your Pet Ever Had Any Reaction To Vaccines? | Yes |
| | No |
| | option1 |
| | option2 |
| Has Your Pet Ever Had Any Reaction To Medications? | Yes |
| | No |
| Has Your Pet Ever Had Any Reaction To Anesthesia? | Yes |
| | No |
| | option1 |
| | option2 |
| Is Your Pet Currently On Any Medication(s)? | Yes |
| | No |
| | option1 |
| | option2 |
| If "Yes", Please List The Name Of The Medication And The Dosage: | |

HAS YOUR PET SHOWN ANY SIGN OF THE FOLLOWING?:

| | |
|---|---|
| Vomiting? | Yes |
| | No |
| Diarrhea? | Yes |
| | No |
| Listless? | Yes |
| | No |

| | |
|---|---|
| No Appetite? | Yes<br>No |
| Weakness? | Yes<br>No |
| Coughing? | Yes<br>No |
| Gagging? | Yes<br>No |
| Scratching? | Yes<br>No |
| Shaking Head? | Yes<br>No |
| Scooting? | Yes<br>No |
| Seizures? | Yes<br>No |
| Abnormal Amount Of Urination? | Yes<br>No |
| Abnorma Amount Of Drinking? | Yes<br>No |
| Limping? | Yes<br>No |
| Abnormal Weight Loss Or Gain? | Yes<br>No |
| Unusual Lumps Or Bumps? | Yes<br>No |

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Annual Wellness Exam

Intestinal Parasite Exam

Deworm (If Needed)

Heartworm Test

FELV Test

FIV Test

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Grooming

Other (Please Specify):

May We Sedate/Anesthesize Your Pet If Necessary?

Yes

No

By Clicking The "Submit" Button, I Agree With All Of The Following:The practice is to use all reasonable precaution against injury, escape, or death of my pet. The practice and staff WILL NOT be held liable for any problems that develop provided reasonable care and precautions are followed. I understand that ANY problem that develops with my pet while I'm absent will be treated as deemed best by the staff veterinarians and I ASSUME FULL RESPONSIBILITY for the treatment expense involved. I agree to pay fees for all services rendered at the time my pet is discharged from the practice or the service is otherwise terminated. I agree to pay for the reasonable costs of collection, attorneys fees and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the practice is located. If I neglect to pick up my pet within 7 days of the date below and do not notify the practice within that time frame, the practice may assume that the pet is abandoned and is hereby authorized to dispose of the pet as deemed best and/or necessary.

NEW CLIENT INFORMATION FORM

NEW CLIENT INFORMATION FORM

Date:

Owner's Name:

Owner's Address:

Street 1:

Street 2:

City:

State:

Zip:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Employer:

How did you become aware of us?

Pet's Name:

Pet's Breed:

Pet's Color:

Pet's Sex:

Pet's Date Of Birth:

Date Of Most Recent Vaccinations:

May we contact your previous veterinarian for a records transfer?

Previous Clinic's Name:

Street 1:

Street 2:

Previous Clinic's Address:

City:

State:

Zip:

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

NEW CLIENT INFORMATION FORM

Date:

Owner's Name:

Street 1:

Street 2:

Owner's Address:

City:

State:

Zip:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Driver's License Number:

How did you become aware of us?

May we contact your previous veterinarian for a records transfer?

Previous Clinic's Name:

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

Email Address