



# 2019 NEW CLIENT FORM

Staff Init/Date:- \_\_\_\_\_

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

Name \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Place Of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Best Time to Reach You \_\_\_\_\_ Driver's Lic# (For payment purposes) \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## All Fees Are Due In Full At The Time Services Are Rendered

Please indicate preferred method of payment:  Cash  Check  Visa/Mastercard  AMEX  Discover  Care Credit

Delinquent accounts are subject to interest of 18% annually. Legal fees and collection costs are the responsibility of the client and are approved \_\_\_\_\_  
**Please Initial Above**

How did you become aware of our clinic?  Drove by  Yelp  Referred By \_\_\_\_\_  
 Yellow Pages  Google  Yahoo  Facebook  Other Internet Search

May we have permission to use you and/or your pet's image in our clinic media content (e.g. Facebook page) ? Yes/No \_\_\_\_\_  
**Please circle AND initial**

## PATIENT INFORMATION

	PET # 1	PET # 2	PET # 3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX: SPAYED OR NEUTERED?			
ANY VACCINATION/MEDICATION ALLERGIES			
ANY SPECIAL DIETS OR MEDICATIONS			

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

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

Name/address of previous veterinarian? \_\_\_\_\_

Who is you pet health insurance provider? \_\_\_\_\_

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