



NEW CLIENT / PATIENT INFORMATION

Today's Date _____

Client's Name _____ Spouse's Name _____

Home Address _____ Apt.# _____ Home Phone Number _____

City _____ State _____ Zip Code _____ Email _____

EMPLOYER _____ SPOUSE'S EMPLOYER _____

ADDRESS _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

WORK PHONE NUMBER _____ EXT. _____ WORK PHONE NUMBER _____ EXT. _____

CELL PHONE NUMBER _____ CELL PHONE NUMBER _____

HOW DID YOU FIND OUR HOSPITAL? (CIRCLE ONE) INTERNET YELLOW PAGES SIGN MAILER REFERRED NEWSPAPER OTHER

WHOM MAY WE THANK FOR REFERRING YOU? _____

PET'S NAME _____ BREED _____ SEX _____ COLOR/DESCRIPTION _____

MICROCHIP NUMBER _____ BIRTH DATE _____ DATE OF LAST VACCINATION _____

(CIRCLE ONE) NEUTERED (MALE) SPAYED (FEMALE)

PET'S NAME _____ BREED _____ SEX _____ COLOR/DESCRIPTION _____

MICROCHIP NUMBER _____ BIRTH DATE _____ DATE OF LAST VACCINATION _____

(CIRCLE ONE) NEUTERED (MALE) SPAYED (FEMALE)

For the safety of your pet and our veterinary team, please answer the following questions:

- Has your pet ever attempted to bite, scratch, or shown any other aggressive or fearful behaviors either at home or at a veterinary facility? Yes / No
- Does your pet show signs of anxiety when visiting a veterinary office? Yes / No
- Is your pet's behavior better or worse if he or she is separated from you while being treated? Better / Worse

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE RENDERED

PLEASE CIRCLE YOUR METHOD OF PAYMENT

Cash Debit VISA MasterCard American Express Discover Card Care Credit

BIRTH DATE _____ DRIVER'S LIC NO. _____ STATE _____ EXP DATE _____

SIGNATURE OF OWNER _____

PERSON PRESENTING THIS PET FOR TREATMENT OTHER THAN OWNER...

NAME (PLEASE PRINT) _____ SIGNATURE _____

RELATIONSHIP TO OWNER _____

ADDRESS OF NON-OWNER _____ PHONE NUMBER _____

CITY _____

PREFERRED METHOD OF CONTACT WITH OUR PRACTICE

TELEPHONE _____ EMAIL _____

TEXT MESSAGE (CELL PHONE NUMBER) _____ CELL PHONE PROVIDER _____

FAX _____