New Client Form

Mrs. ___ Mr. ___ Ms. ___ Dr. ___
First name: _____ MI: _____ Last name: _____
Address: _____
City: _____State: _____ ZIP: _____
Home phone: (____) _____ Work: (____) _____
Cell: (____) _____Email: _____

How did you hear about us?

Yellow Pages ____ Website ____ Internet ____ Hospital sign ____
Personal recommendation ____ (Whom can we thank? _____)
Other: _____

How much information do you want to be given about your pet's health?

❑ I want a full explanation—anything and everything.
❑ I want a brief explanation—just the important stuff.
❑ I just want to know if there's anything I need to do—keep it simple.

Pet information

Name: _____ Age/Birthday: _____
Species (cat, dog, etc.) _____Breed _____
Color _____Weight _____ Male ❑ Female ❑ Spayed/neutered? Yes ❑ No ❑
Does your pet have allergies? Yes ❑ No ❑
Has your pet ever had a reaction to vaccines or medications? Yes ❑ No ❑
If yes, what? _____
List any behavior problems we need to be aware of:
_____

Vaccine History

Canine	Date	Feline	Date
❑ Distemper	_____	❑ FVRCP	_____
❑ Lepto	_____	❑ Leukemia	_____
❑ Bordetella	_____	❑ Rabies	_____
❑ Rabies	_____	❑ FIV/FELV	_____
❑ Heartworm	_____	❑ Fecal	_____
❑ Fecal	_____	❑ Other _____	_____
❑ Other _____	_____		

Method of payment today

Payment is required at the time of service. For your convenience, we accept Mastercard, Discover, Visa, American Express, cash, or check (with a valid driver's license).