



# New Client or Patient Form

We are pleased that you have chosen our office for your pet's needs. In order for us to maintain accurate records, please fill out this form as completely as you can. We look forward to working with you in maintaining your pet's health.

## Client Information

### Your Information

Mr. / Mrs. / Ms.: (first and last)

Street Address:

City, State, ZIP:

County:

Home Phone Number:

Cell Phone Number:

Pager:

E-mail Address:

Driver's License Number:

Employer:

Work Street Address:

## Patient Information

Name:

Breed:

Color(s):

Microchip Number:

Does your pet have any known medical problems? (check one)  
**yes / no**

When was your pet last seen by a veterinarian?

Previous Veterinarian:

Previous Veterinarian's Phone Number:

How did you learn about our hospital? (check one)  
phone book / sign / our website /  
a friend (name: \_\_\_\_\_)

Office Use Only | Updated File: \_\_\_\_\_ TY sent: \_\_\_\_\_ Reference TY sent: \_\_\_\_\_ | Office Use Only

### Spouse / Co-Owner's Information

Mr. / Mrs. / Ms.: (first and last)

Street Address: (check here if same as yours )

City, State, ZIP:

County:

Home Phone Number:

Cell Phone Number:

Pager:

E-mail Address:

Driver's License Number:

Employer:

Work Street Address:

Species:

Birthday / Age:

Gender (check one):  
**male / female**

When was your pet last vaccinated?

If so, please list:

We will gladly prepare a written estimate of service fees if you desire (please ask our doctor or nurse). **All professional fees are due at the time services are rendered.** We accept cash, major credit cards and checks with proper identification.

Signature:

Date: \_\_\_\_\_