NEW CLIENT INFORMATION FORM
NEW PATIENT INFORMATION FORM

Date: ______________

Primary Owner: Dr. / Mr. / Mrs. / Ms. / Miss:

____
(Last Name) (First Name)

Spouse or Co-owner: ____
(Last Name) (First Name)

Address: ____
(Street) (City) (State) (Zip)

Preferred Phone Number: ____

Alternate Phone Numbers: ____

Email: ____

Patient's Name: ______________________ Dog ( ) Cat ( ) Breed: ______________________

Color(s): ______________________ Sex: ________ Altered / Spayed / Neutered? ________

Date of Birth: _____/_____/______ or Age: ________ How long have you had this pet? ____________

Does your pet have a microchip? ________ Microchip Number: ________________________________

Date of last vaccination against Distemper group: ______________________________________

Date of last vaccination against Lyme disease (dogs) or Leukemia (cats): ___________________

Rabies expiration date: _______________ Other vaccines: _________________________________

Environment - Indoors: ______________ Outdoors: ______________ Both: ______________________

Diet (be specific regarding brand names, amount, and frequency): ___________________________

____

Vitamins or Medications? ____

Date of last heartworm test (dogs): ___________ On preventative? ________Which? ________________

Prior medical problems and approximate dates: ______________________________________

____

Method of payment: Cash ( ) Check ( ) Credit Card ( )

Driver's License #: ____ State: _____________________

Employer: ____

Employer's Address: ____

*** Employer info and driver's license # are required when using checks or if hospitalization is required.**

How did you decide to come to us? ____
(If you were referred by another client, please identify so that we may thank them.)