



Alamo  
Animal  
Hospital

## New Client Registration Form

### Owner's Name

#### NAME\*

\_\_\_\_\_

First

\_\_\_\_\_

Last

#### ADDRESS\*

\_\_\_\_\_

Street Address

\_\_\_\_\_

Address Line 2

\_\_\_\_\_

City

\_\_\_\_\_

State/Province/Region

#### DAY-TIME PHONE\*

#### MOBILE PHONE

#### EMAIL\*

**Co-owner's Name & Contact #**

**NAME**

First

Last

**PHONE**

**HOW DID YOU FIND OUT ABOUT OUR PRACTICE?**

Clinic Location

Personal Referral

Internet search/Website

Yellow Pages

Clinic Sign

Newspaper/ Print Media

Other

**IF OTHER, PLEASE SPECIFY:**

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**IF PERSONAL REFERRAL, IS THERE SOMEONE WE CAN THANK FOR THIS REFERRAL?**

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**PLEASE USE THIS AREA TO GIVE US ANY OTHER RELEVANT INFORMATION ABOUT YOURSELF OR YOUR FAMILY**

## **Pet Information**

**PET'S NAME\***

**SPECIES\***

**OR IF OTHER SPECIES**

**BREED (IF KNOWN)**

**COLOR**

**DATE OF BIRTH OR AGE (IF KNOWN)**

**SPECIAL IDENTIFICATION (TATTOO, MICROCHIP, ETC.)**

**SEX**

**PREVIOUS VETERINARY PRACTICE (IF ANY)**

**PREVIOUS VETERINARIAN (IF ANY)**

**DATE OF LAST VACCINES (IF KNOWN)**

**WHAT VACCINES WERE GIVEN AT THIS TIME**

**IS YOUR PET ON ANY MEDICATION OR SUPPLEMENT?**

Yes

No

**IF YES, PLEASE LIST THE MEDICATION OR SUPPLEMENT**

**WHAT FOOD DOES YOUR PET EAT?**

**DOES YOUR PET HAVE ALLERGIES OR DRUG REACTIONS?**

Yes

No

**IF YES, PLEASE LIST THE ALLERGIES AND REACTIONS**

**ARE THERE ANY CURRENT OR PAST MEDICAL CONDITIONS OF WHICH WE SHOULD BE AWARE?**

Yes

No

**IF YES, PLEASE COMMENT ON THE CONDITION(S) AND INDICATE IF THEY ARE CURRENT OR PAST CONDITIONS**

**PLEASE USE THE FOLLOWING BOX TO GIVE US ANY OTHER RELEVANT INFORMATION ABOUT YOUR PET**