

NEW CLIENT FORM

*Thank you for giving us the opportunity to care for your pet(s).
So that we may be come better acquainted, please complete the following:*

CLIENT INFORMATION

Date _____

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Work Phone _____ Spouse's Work Phone _____

Place of Employment _____ Date of Birth _____

Social Security # _____ E-mail Address _____

All Fees Are Due At The Time Services Are Rendered

Please indicate choice of payment: Cash / Check Visa MasterCard Discover

How did you become aware of our clinic: Drove by Yellow Pages Previous Client

Personal Recommendation (*Whom may we thank?*) _____

PATIENT INFORMATION

	PET #1	PET #2	PET #3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX; SPAYED OR NEUTERED?			

YOUR PET'S VACCINATION HISTORY:

RABIES			
DHLP PARVO CORONA			
BORDETELLA			
HEARTWORM TEST/PREVENTION			
RABIES			
FVRCP			
LEUKEMIA TEST			
FELV VACC			
FECAL (STOOL SAMPLE)			

Our pet(s) is: Member of our family Child's pet Backyard Pet

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

Would you like to be present during treatment to your pet? Yes No

ALL accounts are due when services are rendered. ALL accounts unpaid after 30 days will be charged a FINANCE CHARGE at a periodical rate of 1.5% per mo. on the unpaid balance owed at the previous billing cycle, less any payments or credits received. Owner agrees to pay all cost of collection including reasonable attorney fees agreed to be 33.33% of all amounts collected.

Signature _____ Date _____