

# Animal Care Clinic New Patient Form

Please fill out this form as completely as possible. Let us know if you have any questions.

## Client Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Email \_\_\_\_\_ Business Address \_\_\_\_\_

## Spouse/Co-Owner

Spouse/Co-Owner \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_ Business Email \_\_\_\_\_  
Business Phone \_\_\_\_\_ Business Address \_\_\_\_\_

## Emergency Contact

Contact Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_ Business Email \_\_\_\_\_  
Business Phone \_\_\_\_\_ Business Address \_\_\_\_\_

## Pet Information

Pet's Name \_\_\_\_\_ Dog Cat Other \_\_\_\_\_ Age/Birthdate \_\_\_\_\_  
Sex M F Breed \_\_\_\_\_ Color \_\_\_\_\_  
Spayed/Neutered Yes No At What Age? \_\_\_\_\_ Age Obtained \_\_\_\_\_ months/years  
Pet Obtained From Friend Breeder Pet Shop Humane Society Other \_\_\_\_\_  
Purpose For Which Obtained Companionship Protection Breeding Show Other \_\_\_\_\_  
Diet (Kind Of Pet Food) \_\_\_\_\_

Pet's History - Check All That Apply

DHLP (Distemper - Dog)	Feline Leukemia Test (Cat)	Rabies (Dog/Cat)
Parvovirus (Dog)	FVRCP (Infectious Diseases - Cat)	Dentist

Describe Any:

Prior Illness \_\_\_\_\_ Prior Surgery \_\_\_\_\_

Reason For Pet's Visit \_\_\_\_\_

## Payment

We will gladly prepare a written estimate of service fees if you desire (please ask our doctor or receptionist). All professional fees are due at the time services are rendered. In cases of extensive medical or surgical procedures where full payment may be difficult at discharge, we accept major credit cards or can establish a payment arrangement if approved in advance of treatment. There will be a service charge for any check returned unpaid.

To prevent the spread of infectious diseases, all hospitalized patients must be current on all vaccines and free from internal and external parasites. The signature below authorizes this level of preventive care and the appropriate charges will be assessed in the discharge invoice.

Signature Of Client Responsible For Pet(s) \_\_\_\_\_ Date \_\_\_\_\_