

# NEW CLIENT FORM

*Thank you for giving us the opportunity to care for your pet(s).  
So that we may become 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 \_\_\_\_\_