



NEW CLIENT/PET FORM

Today's Date: _____
 Owner's Name: _____
 Owner's Pronouns (She/He/They): _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 E-mail _____ Spouse _____ Phone: _____
 Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear about us? Yellow Pages Hospital Sign Website
 Referral (whom may we thank?) _____

Doctor Preference: **Dr. Parr** **Dr. Herda** **Dr. Hernandez** **None**

Nutrition:

Dry Brand _____
 Canned Brand _____ Table Scraps? **YES** **NO**

Are there other pets in your household? **YES** **NO**

YES If yes, please indicate quantity below:
 Dog ___ Cat ___ Bird ___ Reptile ___ Rabbit ___

Other (please specify) _____

Pet's Information _____

Birthday: _____
 Species _____ Color _____
 Breed _____
 Female Spayed **YES** **NO**

Male Neutered **YES** **NO**

Where was your pet acquired? _____

Medical Conditions (Allergies, drug reaction, heart conditions, etc.) _____

Medical Records (Name of Hospital where they can be obtained) _____

Payment is expected at the time services are rendered. We accept Cash, Visa, MasterCard, Discover, American Express, Debit, and Care Credit. A check may be written after you are an established client. A Driver's License or State ID is required when writing a check.

