



CLIENT INFORMATION FORM

Welcome! Thank you for giving us the opportunity to care for your pet. Please help us meet your needs better by taking a moment to complete this form.

DATE _____ EMAIL ADDRESS _____

OWNER S NAME _____ SPOUSE/OTHER _____

ADDRESS _____ CITY/STATE _____

HOME PHONE _____ CELL _____ WORK _____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

IN THE EVENT OF AN EMERGENCY WHOM SHOULD WE CONTACT?

NAME _____ PHONE _____

	PET 1	PET 2	PET 3
NAME			
DOG/CAT/OTHER			
AGE/BIRTHDATE			
MALE/FEMALE			
NEUTERED/SPAYED			
DATE OF LAST VACCINATION			
MICROCHIPPED?			
ANY KNOWN ALLERGIES?			
ANY HISTORY OF SEIZURES?			
ON ANY CURRENT MEDICATIONS?			
ON A SPECIAL DIET?			
ON HEARTWORM PREVENTION?			
ON FLEA/ TICK PREVENTION?			
ANY VACCINE REACTIONS?			

ANY SPECIAL CONCERNS THAT YOU MAY HAVE? _____

PAYMENT

Payment is expected at the time that services are rendered. We accept personal checks with proper identification. We also accept Cash, Visa, MasterCard, Discover, and CareCredit.

SIGNATURE OF CLIENT RESPONSIBLE FOR PET(S) _____