Today's Date ___/___/____

Client Information Form

Mrs.___ Mr.___Ms.___
First Name: ________________________________ MI: __ Last Name:________________________________
Address: ____
City: ____________________________________ State: ___________________ Zip code: ________________
Primary Phone: (___)________ Secondary Phone: (___)________ Email Address: ____________________

How did you hear about us?

Website [ ] Television [ ] Hospital Sign [ ] Radio [ ] Personal Recommendation [ ]
Other: ____

Method of Payment Today

Payment is required at the time of service. For your convenience, we accept MasterCard, Visa, American Express, cash, or check (with a valid driver's license)

Please check one:
Cash [ ] Check [ ] Debit/Credit Card [ ]

Pet Information

Name: ____ Age/Birthday: ______________________
Species: ___________________ Breed: _______________________ Color: ____________ Weight: _______
Male [ ] Female [ ] Spayed/Neutered? Yes [ ] No [ ]
Does your pet have any allergies? Yes [ ] No [ ]
Has your pet ever had a reaction to vaccines or medication? Yes [ ] No [ ]
If yes, what? ____
List any major surgeries your pet has had: ____
____
List any behavior problems we need to be aware of: ____
____
List any food or treats you give your pet: ____
____

Consent

You will be asked to sign a health plan confirming authorization of treatment after a tentative diagnosis. The details of treatment, the risks of treatment, and/or the risks of not treating will be explained to you.