

# New Client Form

Patient Number: \_\_\_\_\_

Referred By: \_\_\_\_\_

Greeting (circle):      Dr. Mr. Mrs. Ms.

Name of Head  
of Household: \_\_\_\_\_

(last)

(first)

Name of  
Spouse: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

COUNTY: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Office Phone : \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact if Owner cannot be reached:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

PAYMENT REQUIRED WHEN SERVICES ARE PERFORMED    PLEASE CIRCLE  
PAYMENT PREFERENCE BELOW

CASH    CHECK    MASTER CARD    VISA    DISCOVER    AMEX

CARD # \_\_\_\_\_ Expiration DATE \_\_\_\_\_

CARD Signature \_\_\_\_\_ SS# \_\_\_\_\_

WHILE YOUR PET IS WITH US, HE/SHE WILL RECEIVE THE BEST OF CARE AND SUPERVISION.  
INCIDENTS DO ARISE ON OCCASION THAT REQUIRE TREATMENT OF UNEXPECTED PROBLEMS,  
INCLUDING FLEA CONTROL. SHOULD A PROBLEM OCCUR, WE NEED PERMISSION TO TREAT

YOUR PET. WE'LL MAKE EVERY ATTEMPT TO CONTACT YOU ABOUT ANY INCIDENT.

I'VE READ THE ABOVE AND GIVE VWAH PERMISSION TO TREAT MY PET SHOULD THE NEED ARISE.

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SIGNATURE OF OWNER

INDIVIDUAL PET INFORMATION

NAME Pet is Called: \_\_\_\_\_

Circle Species: DOG CAT BIRD OTHER

BREED: \_\_\_\_\_

Circle Sex MALE FEMALE

Birth Date (mm/dd/yyyy): \_\_\_\_\_

COLOR: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

Circle Neutered: YES NO

Previous Animal Hospital

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VACCINATION HISTORY - (LIST DATES GIVEN)

DOG:

DHLP: \_\_\_\_\_ Bordetella: \_\_\_\_\_

Parvo: \_\_\_\_\_ Rabies 1 Yr: \_\_\_\_\_

Corona: \_\_\_\_\_ Rabies 1 Yr: \_\_\_\_\_

Lyme: \_\_\_\_\_

Last Heartworm Results: \_\_\_\_\_ Date: \_\_\_\_\_

Last Fecal Results: \_\_\_\_\_ Date: \_\_\_\_\_

CAT:

Rabies 1 Yr: \_\_\_\_\_

Rabies 3 Yr: \_\_\_\_\_

FVRCPP (Feline Distemper):

Feleuk (Feline Leukemia):

FIP (Feline Infectious Peritonitis):

FIV (Feline Immunodeficiency virus):