All Pets Medicine, Surgery, and Rehabilitation Clinic, PA

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 _____

Primary Phone _____ Secondary Phone _____

Place Of Employment _____ Best Time To Reach You _____

Driver's License # _____ E-Mail Address _____

All Fees Are Due At The Time Services Are Rendered

Please indicate choice of payment. □ Cash / Check □ Visa □ MasterCard Care Credit

How did you become aware of our clinic? □ Drove by □ Yellow Pages □ Previous Client □ Other _____

□ Personal Recommendation *(Whom may we thank?)* _____

	PET # 1	PET # 2	PET # 3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX; SPAYED OR NEUTERED?			
YOUR DOG'S VACCINATION HISTORY:			
RABIES			
DISTEMPER			
BORDETELLA (KENNEL COUGH)			
FECAL (STOOL SAMPLE)			
HEARTWORM TEST/PREVENTION?			
YOUR CAT'S VACCINATION HISTORY:			
RABIES			
DISTEMPER			
LEUKEMIA TEST			
LEUKEMIA			
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