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Welcome 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

Name: _____ Spouse's Name: _____ Last Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Do you give us permission to send you Text Messages? _____

Driver's License #: _____ DOB _____

Email Address: _____

(If you would like to be able to refill prescriptions, check your pet's vaccination due dates, get 24-hour access to your pet's health information, and much more, all you need is an email address!)

How did you become aware of our clinic? Drove by Phone Book Client Internet

Who may we thank for their referral? _____

If your pet ever becomes lost, do we have permission to release your contact information so that we may help reunite your pet? No Yes

Address Phone Numbers Both (Check all information that we may release)

I understand that all fees are due at the time services are rendered and agree to these terms

Signature

Date

Patient Information for Pet #1

Name:	Breed:	Age or Date of Birth:				
Cat <input type="checkbox"/>	Dog <input type="checkbox"/>	Avian <input type="checkbox"/>	Other <input type="checkbox"/>	Color:		
Female <input type="checkbox"/>	Spayed? Yes <input type="checkbox"/>	No <input type="checkbox"/>	Male <input type="checkbox"/>	Neutered? Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is your pet current on vaccinations: Yes <input type="checkbox"/>						No <input type="checkbox"/>
Our pet is: <input type="checkbox"/> A Member of our family <input type="checkbox"/> A Child's Pet <input type="checkbox"/> A Backyard Pet						
Any previous serious illnesses or surgeries?						
Any allergies to vaccinations and/or medications?						
Is your pet on any special diet or medications?						

Patient Information for Pet #2

Name:	Breed:	Age or Date of Birth:				
Cat <input type="checkbox"/>	Dog <input type="checkbox"/>	Avian <input type="checkbox"/>	Other <input type="checkbox"/>	Color:		
Female <input type="checkbox"/>	Spayed? Yes <input type="checkbox"/>	No <input type="checkbox"/>	Male <input type="checkbox"/>	Neutered? Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is your pet current on vaccinations: Yes <input type="checkbox"/>						No <input type="checkbox"/>
Our pet is: <input type="checkbox"/> A Member of our family <input type="checkbox"/> A Child's Pet <input type="checkbox"/> A Backyard Pet						
Any previous serious illnesses or surgeries?						
Any allergies to vaccinations and/or medications?						
Is your pet on any special diet or medications?						