

CLIENT INFORMATION FORM	Date:	Client #
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Owner's Name:

Owner's Street Address:

City:	State:	Zip:
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Home Phone:	Cell Phone:	Work Phone:
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E-mail Address:

Owner's Employer:

Owner's Drivers' License # or State ID #:

Spouse/Partner Name:

Spouse/Partner Employer:	Work Phone:
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Your preferred method of payment:	<input type="checkbox"/> Cash	<input type="checkbox"/> Check	<input type="checkbox"/> Visa/MC/Discover
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OUR PAYMENT POLICY: Payment is due **in full** at time of service. Any other arrangements must be made with the doctor prior to treatment. We do not accept insurance as payment. The client is responsible for submitting pet insurance claims to their insurer for reimbursement. **Please acknowledge that you understand our policy by signing on the line below.*

X _____ Date: _____

*****FILL OUT ONLY FOR PET(S) BEING SEEN ON YOUR FIRST VISIT*****

Information for Pet #1	Information for Pet #2
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Name:	Name:
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Date of Birth:	Age:	Date of Birth:	Age:
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Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spayed	<input type="checkbox"/> Neutered	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spayed	<input type="checkbox"/> Neutered
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Breed:	Breed:
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Color:	Color:
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Date of last vaccination:	Date of last vaccination:
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Type of last vaccination:	Type of last vaccination:
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Date of last heartworm check:	Date of last heartworm check:
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Pet is: <input type="checkbox"/> Indoors	<input type="checkbox"/> Outdoors	<input type="checkbox"/> Both	Pet is: <input type="checkbox"/> Indoors	<input type="checkbox"/> Outdoors	<input type="checkbox"/> Both
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Information for Pet #3	Information for Pet #4
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Name:	Name:
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Date of Birth:	Age:	Date of Birth:	Age:
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Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spayed	<input type="checkbox"/> Neutered	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spayed	<input type="checkbox"/> Neutered
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Breed:	Breed:
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Color:	Color:
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Date of last vaccination:	Date of last vaccination:
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Type of last vaccination:	Type of last vaccination:
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Date of last heartworm check:	Date of last heartworm check:
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Pet is: <input type="checkbox"/> Indoors	<input type="checkbox"/> Outdoors	<input type="checkbox"/> Both	Pet is: <input type="checkbox"/> Indoors	<input type="checkbox"/> Outdoors	<input type="checkbox"/> Both
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How did you find out about our hospital? Please check all that apply:

- Referred by a friend or relative? What is their name?
- Yellow Pages
- White Pages
- Heard Dr. Clemons on the radio
- I am a former client
- Location/Saw sign
- Website
- Other (please specify):