

**NEW CLIENT / PET INFORMATION FORM**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Spouse's Cell: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

**Pet's Name:** \_\_\_\_\_

**Pet Information: Species** (Circle One) Dog Cat Bird Ferret Rabbit Other      **Sex:** (Circle One) Male Female

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Neutered / Spayed ? (Circle One) YES NO

**Vaccination History / Previous Clinic:** \_\_\_\_\_ Phone Number \_\_\_\_\_

Please provide current records if possible

<u>Dog Vaccines</u>	<u>Date Given</u>
Distemper	_____
Parvo	_____
Lepto	_____
Kennel Cough	_____
Rabies	_____

<u>Cat Vaccines</u>	<u>Date Given</u>
Distemper	_____
Leukemia	_____
Rabies	_____
F.I.V	_____

**Parasite Exam History:**

<b>Dog:</b>	<b>Date</b>
Stool Test	_____
Heartworm Test	_____

<b>Cat</b>	<b>Date</b>
Stool Test	_____
Leukemia / Fiv Test:	_____

Has your pet ever had a drug or vaccination reaction? \_\_\_\_\_ Explain: \_\_\_\_\_

Has your pet ever had a seizure? \_\_\_\_\_

Is your pet on any medications? If so, please list: \_\_\_\_\_

Does your pet have any allergies? If so, please list: \_\_\_\_\_

How did you hear about Sugarloaf Animal Hospital ? (Circle)

1. Sign 2. Yellow Pages 3. Advertisement 4. Recommendation: Please Name: \_\_\_\_\_

5. Other: \_\_\_\_\_

Do you have any other pets ? If so, please give names and species and indicate if they are patients here.

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_

Please read and sign where indicated:

I hereby authorize the doctors of Sugarloaf Animal Hospital to render treatment that is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any emergency circumstances, the staff will make every attempt to contact me or my designated representative, before proceeding with treatment, if time permits. I understand that I will be financially responsible for all services rendered on the day of service and a deposit may be required. We accept Cash, Visa ,MC, Discover, Debit, American Express and Care Credit

**Method of payment:** Cash \_\_\_\_\_ Credit Card \_\_\_\_\_ Debit Card \_\_\_\_\_ Care Credit \_\_\_\_\_

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Date

