

NEW CLIENT INFORMATION FORM

Please fill out the following:

Last Name: _____

First Name: _____ Spouse Name: _____

Street: _____

City, State, Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Spouse Employer: _____ Work Phone: _____

E-Mail address: _____

How did you select our Clinic (i.e.: yellow pages, location, personal referral)?

If referred by one of our clients, please enter name:

**PAYMENT IS DUE AT THE TIME OF SERVICES.
WE ACCEPT CASH, CHECK OR CREDIT CARDS.**

If method of payment is by personal check, we must have the following information:

Driver License # _____ Client Date of Birth _____

I declare that all the information that I have provided above is true. I have read the above payment policy, understand that full payment is due at the time of services, and I agree to make full payment upon services rendered.

Signature: _____

Date: _____

PET INFORMATION

Pet's Name: _____

Species: (Circle One) Dog, Cat, Bird, Other _____

Sex: (Circle One) Female, Female Spayed, - Male, Male Neutered _____

Breed: _____ Color : _____ Date of Birth : _____