NEW CLIENT FORM

Last Name: ________________________________ First Name: ____

Spouse/Other: Last Name: ____________________________ First Name: _________________________________

Street Address: _____________________________________ City: _____________ State: _____ Zip:__________

Home Phone: ______________________________________ Cell Phone: _________________________________

Work Phone: _______________________________________ Spouse Phone: ______________________________

Email: ____

Patient Information

Name: ______________________________ Species: ( ) Canine ( ) Feline Date of Birth: _________________________

Breed: ______________________________ Sex: ( ) Male ( ) Neutered / ( ) Female ( ) Spayed

Color(s): __________________________________ Other Identifying Marks: ___________________________________

Where did you Acquire your Pet? ( ) Shelter/Rescue ( ) Breeder ( ) Pet Store ( ) Private Home ( ) Other:_____________

How long have you had this Pet: ______________________ Has this Pet been vaccinated before: __________________

Has your Pet had any Allergic Reactions to Previous Vaccines: ( ) No ( ) Yes ( ) No Known Allergies

If yes what was the Reaction to: ____

Is your pet Currently taking any Medications: ____

( ) Monthly Heartworm – If yes what Product are you Currently Using:____

( ) Flea Prevention – If yes what Product are you Currently Using:____

What percentage of time Outdoors does your pet spend: ( ) 25% ( )50% ( ) 75% ( )100%

Other Comments or Previous Medical Problems: ____

I authorize the veterinary team at West Shore Animal Clinic to examine, diagnose, and provide treatment for the pet(s) listed above as deemed necessary. I understand that reasonable efforts will be made to discuss recommended treatments and associated costs, and I agree to be responsible for all charges incurred for services provided.

Signature: ______________________________________