



# 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: \_\_\_\_\_

### Please sign after agreeing to the following:

- Medication refills or written prescriptions can take 3-5 business days to fill
- It is my responsibility to be a positive part of my pet's care. West Shore Animal Clinic will not tolerate any belligerent behaviors
- All payments are expected at the time of service, an estimate of services will be provided to me at my request. We accept cash, check, debit, credit card, care credit, scratch pay, and tap to pay

Signature: \_\_\_\_\_