STARKVILLE VETERINARY HOSPITAL

THANK YOU FOR GIVING US THE OPPORTUNITY TO CARE FOR YOUR PET. PLEASE HELP US MEET YOUR NEEDS BY TAKING A MOMENT TO COMPLETE THIS INFORMATION.

New Client Form

CLIENT INFORMATION

Date____________________

Name ________________________________ Spouse's Name ____________________________
What name would you prefer to be called? ____
Address ______________________________ City _______________ Zip ________________
Phone ___________________ Work phone _____________ Spouse's work phone _____________
Cell phone _______________ Where do you prefer to be reached? ☐ Home ☐ Work ☐ Cell
Best time to call? ___________________ Driver's License or Soc. Sec. # ______________________
Place of employment ______________________________ E-mail address _____________________

PAYMENT IS EXPECTED UPON RECEIPT OF SERVICES

What will be your method of payment today? ☐ Cash ☐ Check ☐ Credit Card

PATIENT INFORMATION

	Pet #1	Pet #2	Pet #3
NAME			
BREED			
DATE OF BIRTH / AGE			
COLOR			
SEX / SPAYED OR NEUTERED			
WHEN LAST VACCINATED			
WHEN LAST HW TEST			
WHAT TYPE OF HWP - WHEN			
FIV / FELV TEST?			

PREVIOUS VETERINARIAN (S) WHERE PAST RECORDS COULD BE OBTAINED IF NECESSARY: ____

____
Any previous serious illnesses or surgeries? ______________________________________
Any allergies to vaccinations or medications? _____________________________________
Is your pet on any special diets or medications? ___________________________________
Would you like to be present during treatment to your pet? ☐ Yes ☐ No
Our pet(s) is: ☐ Member of the family ☐ Child's pet ☐ Backyard pet

HOW DID YOU HEAR ABOUT US? ☐ YELLOW PAGES ☐ DROVE BY ☐ OTHER
INDIVIDUAL WE MAY THANK? ________________________________

WE LOOK FORWARD TO WORKING WITH YOU AND YOUR PET!