

Client ID#: _____

BLUE RIDGE ANIMAL HOSPITAL

NEW CLIENT INFORMATION

THANK YOU FOR GIVING BLUE RIDGE ANIMAL HOSPITAL AN OPPORTUNITY TO CARE FOR YOUR PET. IN ORDER FOR US TO BECOME BETTER ACQUAINTED WITH YOU, PLEASE COMPLETE THE FOLLOWING:

NAME: _____ SPOUSE: _____
 MAILING ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING): _____
 CELL PHONE: _____ WORK PHONE: _____ HOME PHONE: _____
 SPOUSE'S CELL PHONE: _____ SPOUSE'S WORK PHONE: _____

HOW DID YOU BECOME AWARE OF OUR CLINIC?

____ CLINIC SIGN ____ YELLOW PAGES ____ INTERNET
 ____ CLIENT (WHOM MAY WE THANK?) _____

PATIENT INFORMATION

NAME _____
 BREED _____
 COLOR _____
 DOB/AGE _____
 SEX _____ SPAYED OR NEUTERED

NAME _____
 BREED _____
 COLOR _____
 DOB/AGE _____
 SEX _____ SPAYED OR NEUTERED

MEDICAL HISTORY

WHERE WERE THE LAST VACCINATIONS GIVEN? _____
 DATE OF VACCINATIONS _____ PHONE NUMBER _____

HAS YOUR PET HAD ANY PREVIOUS SERIOUS ILLNESSES OR SURGERIES? _____

DOES YOUR PET HAVE ANY ALLERGIES TO VACCINES OR MEDICATIONS? _____

IS YOUR PET ON ANY SPECIAL DIET OR MEDICATIONS? _____

*WOULD YOU LIKE TO BE CONTACTED BY E-MAIL? YES ____ NO ____

E-MAIL: _____

*CONTACTS BY E-MAIL WOULD ONLY BE USED FOR PET REMINDERS AND RESPONSES TO QUESTIONS REGARDING YOUR ANIMALS.

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above-described pet(s). I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid in full at the time of release and that a deposit may be required for treatment.

Signature of Owner _____ Date _____

Method of Payment Today: __Cash __Check __Credit (American Express, Discover, MasterCard, Visa) __CareCredit __Debit