

PineHills Veterinary Hospital

New Client Form

Mrs. ___ Mr. ___ Ms. ___ Dr. ___

First Name: _____ MI: _____ Last Name: _____

Spouse First Name: _____ MI: _____ Last Name: _____

Physical Address: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

Spouse Phone: (____) _____ Email: _____

How did you hear about us?

Yellow Pages Newspaper Television Hospital sign Radio
Personal recommendation (Whom can we thank? _____)
Other: _____

Previous Records:

Would you like PVH to request your pet's records from a previous veterinary clinic? Yes No
If yes, please give us the name of the clinic and phone number if available

Consent

You will be asked to sign a health plan confirming authorization of treatment after a tentative diagnosis. The details of treatment, the risks of treatment, and/or the risk of not treating will be explained to you.

Pet information

Name: _____ Age/Birthday: _____ Species: Dog Cat

Breed _____ Color _____ Weight _____

Male Female Spayed/neutered? Yes No

Does your pet have allergies? Yes No

Has your pet ever had a reaction to vaccines or medications?

Yes No If yes, what? _____

List any major surgeries your pet has had:

List any behavior problems we need to be aware of:

Additional Pets:

Name: _____ Age/Birthday: _____ Species: Dog Cat

Breed _____ Color _____ Weight _____

Male Female Spayed/neutered? Yes No

Does your pet have allergies? Yes No

Has your pet ever had a reaction to vaccines or medications?

Yes No If yes, what? _____

List any major surgeries your pet has had:

List any behavior problems we need to be aware of:

Name: _____ Age/Birthday: _____ Species: Dog Cat

Breed _____ Color _____ Weight _____

Male Female Spayed/neutered? Yes No

Does your pet have allergies? Yes No

Has your pet ever had a reaction to vaccines or medications?

Yes No If yes, what? _____

List any major surgeries your pet has had:

List any behavior problems we need to be aware of:

Name: _____ Age/Birthday: _____ Species: Dog Cat

Breed _____ Color _____ Weight _____

Male Female Spayed/neutered? Yes No

Does your pet have allergies? Yes No

Has your pet ever had a reaction to vaccines or medications?

Yes No If yes, what? _____

List any major surgeries your pet has had:

List any behavior problems we need to be aware of:

Name: _____ Age/Birthday: _____ Species: Dog Cat

Breed _____ Color _____ Weight _____

Male Female Spayed/neutered? Yes No

Does your pet have allergies? Yes No

Has your pet ever had a reaction to vaccines or medications?

Yes No If yes, what? _____

List any major surgeries your pet has had:

List any behavior problems we need to be aware of:
