COUNTRYSIDE VETERINARY CLINIC, LTD.

NEW CLIENT FORM

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following:

CLIENT INFORMATION Date _____

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Work Phone _____ Spouse's Work Phone _____

Place of Employment _____ Best Time To Reach You _____

Driver's License # _____ Social Security # _____

E-Mail Address _____ Cell Phone / Pager _____

All Fees Are Due At The Time Services are Rendered

Please indicate choice of payment: ☐Cash/Check ☐Visa ☐MasterCard ☐Discover

Signature _____

How did you become aware of our clinic? ☐Drove by ☐Yellow Pages ☐Previous Client ☐Newspaper Ad ☐Internet

☐Personal Recommendation *(whom may we thank?)* _____

PATIENT INFORMATION

	PET #1	PET #2	PET #3
NAME			
BREED			
MICROCHIP #			
DATE OF BIRTH			
COLOR			
SEX; SPAYED OR NEUTERED?			
YOUR DOG'S VACCINATION HISTORY:			
RABIES			
DISTEMPER, PARVO, CORONA			
BORDETELLA (KENNEL COUGH)			
LYMES VACCINATION			
FECAL (STOOL SAMPLE)			
HEARTWORM TEST / type of prevention			
YOUR CAT'S VACCINATION HISTORY:			
RABIES			
RCCP (4 in one distemper)			
LEUKEMIA TEST			
LEUKOCELL VACCINATION			
F.I.P. VACCINATION			
FECAL (stool sample)			

Any previous serious illnesses or surgeries? _____

Any reactions 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