New Client Info Form

Owner Information:

Last Name: ________________________________ First Name: __________________________________

Phone Number (Primary): (_______)________________ (Secondary): (______)______________________

Email: _____________________________________ D.O.B(Owner)________________________________

Address: _____________________________ City: ________________ State: __________ Zip: ___________

Co-Owner Information:

Last Name: ___________________ First Name: ________________ Phone Number:___________________

Pet Information:

Patient Name: _____________________________________ Species: K9 / Fel

Breed: _______________________________ Color: _________________ DOB/Age: __________________

Gender: Male / Female Spayed/Neutered? ____________ Diet:_____________________________________

Medical Conditions/ Allergies (*drug reactions, heart condition, etc*):

____

Current Medications (*flea medication, etc*): ___________________ How long have you had your pet: __________

Do you brush your dogs teeth? Yes No Date of last dental cleaning: ______________________________

Vaccination History (*Indicate the date received - or write Not Sure*):

Canine: DHP: _________ Parvovirus: _________ Bordetella: _________ Rabies: _________ Other: ______

Feline: Rabies: ________ FVRCP: _________ Leukemia: _________ Other: ____________

Do you have any other pets? Yes No (*If so, please indicate quantity below*)

Dogs: ____ Cats: ____ Birds: ____ Reptiles: ____ Rabbits: ____ Other: ______________________

Has your pet had any of the following within the past week?

☐ Vomiting ☐ Diarrhea ☐ Cough ☐ Sneezing ☐ Appetite Change ☐ Lethargic /Attitude Change

Do you have pet insurance? Yes No If yes, who is your insurance provider? ___________________________

Does your pet have a primary Dr.? Yes No If yes, ____

Previous Veterinarian Information: _______________________________ Doctor: _______________________

How did you hear about us (We would like to thank them):____

EMERGENCY CONTACT (***In case we can't reach you***)**:**

Name: ____________________________ Phone Number: (_____)_______________ Relationship: _________

Client Signature: _______________________________________ Date: ______________________________

By signing this form, I authorize Dr. Sue Morizi to treat my pet. I acknowledge that payment is required for all services performed by Dr. Sue Morizi.