



Were you **referred** to us? **Yes**  **No**

If yes, **Client First Name:** \_\_\_\_\_

**Client Last Name:** \_\_\_\_\_

# New Client Form

*We are excited you have chosen us to care for your pet and we look forward to assisting you!*

## Client Information

Owner's name (First, Last): \_\_\_\_\_

Phone numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Spouse/Partner name (First, Last): \_\_\_\_\_

Phone numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

## Patient Information

Pet's name: \_\_\_\_\_ Gender:  Male  Female  Neutered  Spayed

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

DOB or Approximate Age: \_\_\_\_\_

Pet's name: \_\_\_\_\_ Gender:  Male  Female  Neutered  Spayed

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

DOB or Approximate Age: \_\_\_\_\_

Medical and vaccination records are required for all new patients. Please have your pet's veterinary records emailed to the email address listed below prior to scheduling their first appointment:

 [Lakealfredah@yourvetdoc.com](mailto:Lakealfredah@yourvetdoc.com)

I understand that *Lake Alfred Animal Hospital* can provide a written prescription upon request for any medications prescribed for my pet, which I may fill at a pharmacy of my choice.

## PAYMENT IS REQUIRED AT TIME SERVICE IS RENDERED

I, the owner or their authorized agent personally assume responsibility for all charges incurred in the care of all animals whom I am the owner or their authorized agent. I understand that these charges must be paid at the time services are performed.

*Lake Alfred Animal Hospital* does accept all major credit cards, cash, checks with valid ID and Care Credit for your convenience.

**Signature of owner/agent:** \_\_\_\_\_ **Date:** \_\_\_\_\_