

Broken Arrow Veterinary Hospital

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 Cell Phone: _____

Place Of Employment: _____ Best Time To Reach You: _____

Driver's License # _____ Client Date of Birth: _____ **Military? (Veteran or Active) Y or N**

E-Mail Address: _____

All Fees Are Due At The Time Services Are Rendered

Please indicate choice of payment Cash/Check Credit/Debit card Care Credit

How did you become aware of our clinic? Drove by Yellow Pages/Google Previous Client Other _____

Personal Recommendation (*Whom may we thank?*) _____

| | PET # 1 | PET # 2 | PET # 3 |
|---------------------------------|---------|---------|---------|
| NAME | | | |
| BREED | | | |
| DATE OF BIRTH | | | |
| COLOR | | | |
| SEX; SPAYED OR NEUTERED? | | | |
| YOUR DOG'S VACCINATION HISTORY: | | | |
| RABIES | | | |
| DHLP PARVO/LEPTO | | | |
| BORDETELLA | | | |
| FECAL (STOOL SAMPLE) | | | |
| HEARTWORM TEST/PREVENTION? | | | |
| MICROCHIP? | | | |
| YOUR CAT'S VACCINATION HISTORY: | | | |
| RABIES | | | |
| FVRCP or HCP | | | |
| LEUKEMIA | | | |
| FIV/FELV TEST | | | |
| FECAL (STOOL SAMPLE) | | | |
| MICROCHIP? | | | |

Our pet(s) is: Member of our family Child's pet Backyard pet

Any previous serious illnesses or surgeries? _____

Any allergies 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

Could we, as a clinic, use photos of your pet(s) on social media? Yes No