New Client Information Form

At The Oaks Pet Hospital Inc.
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AAHA AMERICAN ANIMAL HOSPITAL ASSOCIATION
Healthy Practices. Healthier Pets.

PROFESSIONAL SERVICES ARE TO BE PAID FOR AT THE TIME SERVICES ARE RENDERED.
We Gladly Take Cash, Electronic Checks, Visa/MasterCard, Care credit.

OWNER'S NAME_____ HOME NUMBER_____
ADDRESS_____ CITY_____STATE_____ZIP_____
EMPLOYMENT NUMBER_____ CELL NUMBER_____
SPOUSE NAME_____ SPOUSE TEL. NUMBER_____
EMAIL_____
DRIVER LICENSE NO:_____STATE_____EXP_____ D.O.B._____
SPOUSE DL NO:_____STATE_____EXP_____D.O.B_____
MAY WE CALL YOU AT WORK? YES:_____ NO:_____

PET INFORMATION

	PET 1	PET 2	PET 3
NAME:			
SPECIES: (Cat, Dog, Other)			
BREED:			
DESCRIPTION: (Color)			
AGE: (D.O.B or Years)			
SEX:			
NEUTERED/SPAYED:			
MICROCHIP NUMBER:			
MEDICAL ALERT:			
FOOD/DRUG ALLERGIES:			

VACCINE INFORMATION/HISTORY:

PLEASE PROVIDE THE DATES GIVEN.

CANINE VACCINES			
RABIES: (DOG/CAT 1yr or 3yrs)			
DHPPC: (DISTEMPER/PARVO)			
BORDETELLA (DOG)			
LYME: (DOG)			
FELINE VACCINES			
FVRCP: (Distemper)			
FELINE LEUKEMIA TEST			
FELINE LEUKEMIA VACCINE			
FELINE FIP VACCINE			
FELINE FIV VACCINE			

HOW DID YOU FIND OUT ABOUT OUR HOSPITAL? ☐ Referred by_____
☐ Hospital Sign ☐ Yellow Pages ☐ Web Page ☐ Television

I ASSUME RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF MY ANIMAL(S). I ALSO UNDERSTAND THAT THESE CHARGES WILL BE PAID AT THE TIME OF RELEASE AND THAT A DEPOSIT MAY BE REQUIRED FOR SURGICAL TREATMENT AND HOSPITALIZATION.

OWNER SIGNATURE: _____**DATE:**_____