

New Client/Pet Form



Pet Owner's Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Spouse or Co-Owner Name: _____ Home Phone: _____

Work Phone: _____ Emergency Phone: _____

E-mail address: _____

How did you hear about us? _____

Referred by (We would like to thank them.) _____

Names and ages of children living at home: _____

Medical Conditions that we need to be aware of (allergies, drug reactions, heart conditions, etc.)

Are there other pets in your household? YES NO

If yes, please indicate quantity below:

Dogs: _____ Cats: _____ Birds: _____ Reptiles: _____

Ferrets: _____ Other: _____

Pet information

Pet's Name: _____

Birth Date: _____

Species: _____ Breed: _____ Colour: _____

Female: Spayed YES NO

Male: Neutered YES NO

What does your pet eat?

Dry Brand: _____

Canned Brand: _____

Table Scraps? _____

Vaccination History

(indicate the date (dd/mm/yy) your pet last received the following vaccinations)

Canine

Distemper: _____ Parvovirus: _____

Bordetella: _____ Rabies: _____

Coronavirus: _____ Leptospirosis: _____

Adenovirus type A: _____

Parainfluenza: _____ Other: _____

Feline

Leukemia: _____ Calicivirus: _____

Chlamydia: _____ Rabies: _____

Rhinotracheitis: _____ F.I.V.: _____

Panleukopenia: _____ Other: _____

Dental Care

Do you brush your pet's teeth? YES NO

Date of last in clinic dental cleaning? _____

Medical records

Name of hospital where they can be obtained:
