



# FOUR PAWS & HOOVES

— Veterinary Clinic —

## NEW CLIENT FORM

### YOUR INFORMATION

Name: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Spouse's Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

DL Number: \_\_\_\_\_ SSN: \_\_\_\_\_

Email Address: \_\_\_\_\_ Referred By: \_\_\_\_\_

Are you a senior? \_\_\_\_\_ Are you or your spouse in the military? \_\_\_\_\_

Have you or your patient seen Dr. Tricia before? \_\_\_\_\_

Who is your pet insurance provider? \_\_\_\_\_

### PATIENT INFORMATION

Name: \_\_\_\_\_

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

Color/Markings: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Microchip #: \_\_\_\_\_

Sex: M MC F FS

Previous Health Issues: \_\_\_\_\_

\_\_\_\_\_

Vaccinations given and dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

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

Color/Markings: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Microchip #: \_\_\_\_\_

Sex: M MC F FS

Previous Health Issues: \_\_\_\_\_

\_\_\_\_\_

Vaccinations given and dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Payment is expected at time of service. By signing this paper, you agree to pay for the services rendered during your visit. You also agree that if this account is referred to an attorney/collection agency, you will be responsible for all attorney fees/court costs that ensue.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_