NEW CLIENT FORM

Intown Animal Hospital

Client First Name: _____ **Last Name**: _____

Spouse/Partner First Name: _____ **Last Name**: _____

Address_____**County**_____

City_____**State**_____**Zip**_____

Home Phone: ( )_____ **Mobile Phone**: ( )_____

Work Phone: ( )_____ **Pager**: ( ) _____

Email: _____@_____

(We do not market any products by email; nor do we share, sell or lend this information, we may send reminders or important health related information)

Place of Employment: _____ **Spouse/Partner**_____

Referred By: _____

Patient Information

Name: _____ **Species**: Feline Canine Other _____

Breed: _____ **Color & Markings**: _____

Date of Birth: _____ **Sex**: Male Female Neutered / Spayed?

Does your pet have a microchip? YES / NO Do you know the number?_____

Is your pet current on Vaccines? ____Yes ____No

List any previous surgeries or illnesses: _____

List any known allergies to medications or vaccinations: _____

List any medications that your pet takes: _____

What kind of food does your pet eat? _____

Previous Clinic(s) where we may obtain your pet's records: _____

Payment Policy: Payment is due in full at the time that services are rendered. We do not bill for services. We accept CASH, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS payments. There is a $25.00 fee on returned checks.

By signing this form, I acknowledge I have read, understand, and agree to the Payment Policy

SIGNATURE _____ **DATE** _____