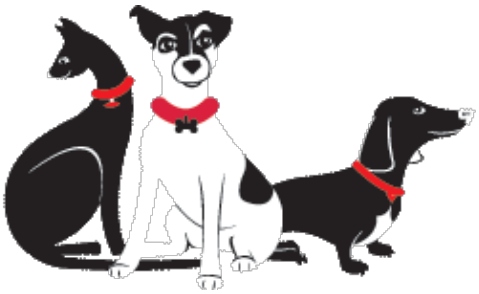
New Client Information



Welcome to Capital Heights Vet Clinic. Please help us provide your pet with the best care possible by completing the information on this form.

First Name: _____Last Name: _____
Secondary Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone:(___)_____ Secondary Phone: (___)_____
Would you like to receive email or text reminders? (circle one)
Email: _____ Employer: _____

How did you hear about us?
Internet___ Driving By___ Client referral (name)_____
Other (specify)_____

Pet Information
Name: _____ Age/Birthday: _____
Species (cat, dog, etc.): _____ Breed: _____
Color: _____ Weight: _____ Male: _____ Female: _____
Spayed/Neutered? yes____ no _____
Is your pet easy to handle? yes _____ no _____
Has your pet ever had a reaction to vaccines or medications? yes/no
Current medications: _____
Prior illnesses: _____
Prior surgeries: _____

Authorization
I hereby authorize the veterinarian to examine, prescribe for, and treat the above described pet for all charges incurred in the care of this animal. I also understand these charges will be paid at the time of release and that a deposit may be required for surgical treatment.
Signature of owner or agent: _____ Date:____/____/____