Lakeview Animal Hospital

New Client Form

Date:
Account:

Client Information

Owner(s)_____ Home Phone_____

Email(s)_____ Cell Phone _____

Address_____ Employer(s)_____

City_____ State_____ Zip _____

Please select your preferred method(s) of notification for reminders: ☐ Phone ☐ Email ☐ Text Message ☐ Mail

How did you become aware of our clinic? ☐ Drove by ☐ Yellow Pages ☐ Website ☐ Social Media ☐ Previous client

☐ Personal referral (whom may we thank?) _____ ☐ Other _____

Would you allow us to feature your pet in social media (last name will be omitted)? ☐ Yes ☐ No

Pet Health History

Pet's Name_____ Species: ☐ Canine ☐ Feline Birthdate *(approx. age)*_____

Breed_____ Color _____

Sex: ☐ male ☐ female Spayed/Neutered: ☐ yes ☐ no

Vaccination History (date and type of last vaccinations) _____

Please check (✓) any symptoms or problems that you have noticed about your pet

☐ Behavior Problems	☐ Limping	☐ Thirst and/or Urination Increase
☐ Breathing Problems	☐ Loss of Balance	☐ Vomiting
☐ Coughing	☐ Scooting	☐ Weakness
☐ Diarrhea	☐ Scratching	☐ Other_____
☐ Eye Bulging or Bloodshot	☐ Seems Depressed	_____
☐ Gagging	☐ Shaking Head	_____
☐ Lack of/Decreased Appetite	☐ Sneezing	_____

Previous veterinarian(s)/Hospital(s) _____

Authorization to obtain medical records: ☐ **Yes**, full medical history ☐ **Yes**, vaccination history only ☐ **No**, not at this time

Current medications _____

Pet's allergies (food, seasonal, medication, etc): _____

Current diet _____

Authorization

Professional fees are to be paid at the time services are rendered. Please check your method of payment below:

Please indicate choice of payment: ☐ Cash ☐ Debit ☐ Visa ☐ Mastercard ☐ Discover ☐ CareCredit

Lakeview Animal Hospital does not accept checks as a form of payment.

No show appointments will require a $50 non-refundable deposit prior to scheduling future appointments.

I am responsible and agree to pay in full the total charges for services rendered at the time of discharge and any fees incurred for the collection of said charges. I understand that the fees are based on treatment deemed necessary at the time of the exam, treatment or admission and that the estimate fee may be raised or lowered by the administration of treatment, medication, surgery, or diagnostic testing.

Signature _____ **Date** _____