



West Salem Animal Clinic New Client Form

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To ensure the best care possible, please take a moment to fill out this form completely. Thank You!

Owner: _____ Co-Owner: _____

Primary Phone _____ please circle: (cell - home - work)

Secondary Phone _____ please circle: (cell - home - work)

Email address: _____

Address: _____ City: _____ State: _____ Zip _____

Place of Employment: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

How Did You Hear of Us? _____ Personal reference *If so, Whom:* _____

____ Sign /Clinic location _____ www.westsalemanimalclinic.com _____ Internet *If so, Where?* _____

Name of Pet(s) being seen today: _____

____ Dog ____ Cat Other _____ _____ Male ____ Neutered _____ Female ____ Spayed

Breed: _____ Color: _____ Birthdate/Age _____

Pet's History

____ Distemper ____ Parvovirus ____ Bordetella ____ CIV ____ Leptospirosis ____ Rabies ____ FVRCP ____ Leukemia

____ Heartworm Test (Dog) ____ On Heartworm Preventative (Dog) ____ Feline Leukemia Test (Cat) ____ Annual Blood Work

____ Dental Procedure ____ Routine Worming

Prior Illness or Prior Surgery: _____

Allergies: _____

Current Medications: _____

Current Supplements: _____

Current Diet: _____

Please list additional pets on the back of this form

AUTHORIZATION

I hereby authorize West Salem Animal Clinic to examine, prescribe for or treat the above described pet. I assume all responsibility for all charges incurred in the care of the animal. I also understand that ALL FEES ARE DUE UPON RELEASE OF THE ANIMAL AND/OR END OF VISIT.



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Signature of client responsible: _____ Date: _____

Pet Name	Birthdate Or Age	Gender	Spayed/ Neutered	Species (Canine/ Feline)	Breed	Current on Vaccinations?
1.						
Previous Medical Concerns/Illness:						
2.						
Previous Medical Concerns/Illness:						
3.						
Previous Medical Concerns/Illness:						
4.						
Previous Medical Concerns/Illness:						
5.						
Previous Medical Concerns/Illness:						
6.						
Previous Medical Concerns/Illness:						
7.						
Previous Medical Concerns/Illness:						
8.						
Previous Medical Concerns/Illness:						
9.						
Previous Medical Concerns/Illness:						