CREEK VIEW VETERINARY CLINIC, PLLC

NEW CLIENT FORM DATE:_____

Thank you for giving us the opportunity to care for your pet/s. Please complete the following so we may become better acquainted.

Client Information (PLEASE PRINT)

NAME:_____ Spouse:_____ Are you a senior over 65?____

Address:_____City:_____ State:_____Zip Code:_____

Primary phone:_____ Spouse's Primary Phone:_____

Place of Employment:_____Work Phone:_____

Best Time of Day to Reach You:_____email address:_____

How would you prefer to be contacted?_____

How did you become aware of our clinic? Web Search, Client Referral, Previous Client, Salon Refferal, Location/Neighborhood, Neighbor to Neighbor, Other_____

If you heard of us by personal recommendation, who may we thank?_____

Please indicate you choice of payment for today's services: **Cash/Check Visa Mastercard Discover CareCredit**

PAYMENT IS EXPECTED AT THE TIME OF SERVICE. For critical care cases a deposit of 50% is required at the time the pet is hospitalized. Returned checks may be processed thru the County District Attorney's office if necessary. A $30.00 returned check charges is assesed to the balance.

	PET 1	PET 2	PET 3
Name			
Species			
Breed			
DOB			
Color			
Sex			
Altered			

DO YOU HAVE ANY OUTSIDE CATS YOU FEED OR CARE FOR? (Y/N) if so, about how many?____

Who do we contact for previous vaccination and medical history?_____

Does your pet/s have any reaction to vaccinations or medications?_____

Is your pet/s on any special diet or medication?_____

Signature of person responsible for pet/s and payment:_____