ALLEN VETERINARY HOSPITAL
5026 DECATUR ROAD
FORT WAYNE, INDIANA 46806
260-744-4121

NEW CLIENT FORM

Thank you for giving Allen Veterinary Hospital the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following:

CLIENT INFORMATION Date _____

Your Name _____

Secondary Name (Relationship) _____

Address _____

City _____ State _____ Zip _____

Home Telephone _____ Cell Telephone _____

Work Telephone _____ Secondary Work Phone _____
***PLEASE INDICATE WHICH TELEPHONE NUMBER IS YOUR PRIMARY PHONE**

Your Drivers License Number _____

Secondary Drivers License Number _____

Your Place of Employment _____

Secondary Place of Employment _____

Your Social Security Number _____

Secondary Social Security Number _____

All fees are due at the time services are rendered.

Please indicate choice of payment ___Cash ___Check ___MC ___Visa ___Discover ___CareCredit

Personal Recommendation (whom may we thank?) _____

By signing I agree that pertinent medical information of my pet(s) can be given to boarding, grooming, and veterinary facilities.

Signature: _____

PLEASE COMPLETE THE PATIENT INFORMATION FORM

PATIENT INFORMATION FORM

	PET #1	PET #2	PET #3
Name			
Breed			
Date of Birth			
Color			
Sex; Spayed or Neutered?			
VACCINATION HISTORY- DOG PLEASE WRITE DATE GIVEN			
Rabies			
Distemper-Parvo			
Kennel Cough			
Heartworm Test			
Heartworm Prevention Used?			
VACCINATION HISTORY- CAT PLEASE WRITE DATE GIVEN			
Rabies			
Distemper (FVRCP&C)			
Feline Leukemia Vaccine			
FIV/Feline Leukemia Test			

VACCINATION HISTORY- CAT
PLEASE WRITE DATE GIVEN

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

Client ID (Office Use Only) _____