

# WELCOME TO HAZEL RIDGE VETERINARY CLINIC



## NEW CLIENT FORM

\_\_\_\_\_  
 Last Name                                      First Name                                      Middle Initial                                      Spouse's Name

\_\_\_\_\_  
 Address Number                      Street                                      City                                      State                                      Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Driver's License Number \_\_\_\_\_

Receive Email Reminders (Circle one) Yes/No

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Wk. Phone \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Wk. Phone \_\_\_\_\_

How Did You Hear About Our Clinic? \_\_\_\_\_

**I authorize the veterinarians at Hazel Ridge Veterinary Clinic and their staff to provide any examinations or treatment as deemed necessary. I understand that I am responsible to pay for all fees as rendered at the time of service.**

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_

Signature of Person Presenting This Pet for Treatment if Other Than Owner \_\_\_\_\_

Address of Non-Owner \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Owner \_\_\_\_\_

### PATIENT INFORMATION

<b>PATIENT # 1</b>		<b>PATIENT # 2</b>	
Pet's Name _____		Pet's Name _____	
Species _____	Breed _____	Species _____	Breed _____
Birthday _____	Color _____	Birthday _____	Color _____
Weight _____	Sex _____	Spay/Neuter? _____	
<u>Date of Vaccinations</u>		<u>Date of Vaccinations</u>	
<u>CANINE</u>	<u>FELINE</u>	<u>CANINE</u>	<u>FELINE</u>
DHPP _____	FVRCP _____	DHPP _____	FVRCP _____
Rabies _____	Rabies _____	Rabies _____	Rabies _____
Other _____	Leukemia _____	Other _____	Leukemia _____
<u>Date of Lab Tests</u>		<u>Date of Lab Tests</u>	
<u>CANINE</u>	<u>FELINE</u>	<u>CANINE</u>	<u>FELINE</u>
Heartworm _____	FeIV/FIV _____	Heartworm _____	FeIV/FIV _____
Fecal _____	Fecal _____	Fecal _____	Fecal _____