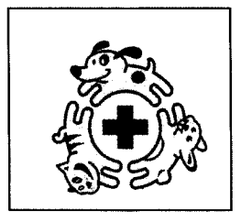
Trinity Pet Hospital



NEW CLIENT FORM

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

CLIENT INFORMATION Date _____

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Work Phone _____ Spouse's Work Phone _____

Place of Employment _____ Best Time to Reach You _____

Driver's License # _____ E-Mail Address _____

All Fees Are Due At the Time Services Are Rendered. We do not bill for services. We will gladly prepare an estimate prior to any treatment.

Please indicate choice of payment. ▯ Cash / Check /Debit ▯ Visa ▯ MasterCard ▯ Discover ▯ Amer/Ex

How did you become aware of our clinic? ▯ Drove by ▯ Yellow Pages ▯ Neighborhood News ▯ Other _____

▯ Personal Recommendation *(Whom may we thank?)* _____

	PET # 1	PET # 2	PET # 3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX; SPAYED OR NEUTERED?			
YOUR DOG'S VACCINATION HISTORY:			
RABIES			
DIST- PARVO- PARAINFLUENZA			
BORDETELLA			
LYME			
FECAL (STOOL SAMPLE)			
HEARTWORM TEST/PREVENTION?			
YOUR CAT'S VACCINATION HISTORY:			
RABIES			
DIST-RHINO CHLAMYDIA			
LEUKEMIA			
LEUKEMIA/ FIV TEST			
FECAL (STOOL SAMPLE)			

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diet or medications? _____

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat, or perform surgery upon the pet(s) as indicated. Furthermore, I agree to pay for services rendered at the time the pet is discharged from the hospital.

Signature(s)_____ Date_____