

TRI COUNTY SMALL ANIMAL HOSPITAL

New Patient Information Sheet

Please fill in the blanks to the best of your knowledge, and leave blank any that you are unsure about or unable to answer. You must be eighteen years of age or older to fill out this form, and in doing so you are responsible for any and all charges that occur.

Owner's Name _____
Address _____
Mailing Address _____
City, State, Zip _____
Home Phone _____
Cell Phone _____
Work Phone _____
Business _____
Social Security # _____
Driver's License # _____
Email _____

Spouse's Name _____
Work Phone _____
Cell Phone _____
Social Security # _____
Method of Payment
CASH ___ CHECK ___ VISA ___ AMEX ___ DISC ___ MC ___

NOTE: (EMAIL ADDRESSES WILL ONLY BE USED FOR SENDING OUT VACCINATION REMINDERS VIA EMAIL.)

Contact Person – A friend or relative who may be assisting in the care of or the transportation of this animal. Person to contact if owner is out of town.

Name: _____ Address: _____
Relationship: _____ Home Phone: _____ Work Phone: _____

How did you learn about our hospital?

- ◇ Because of Location
- ◇ Yellow Pages
- ◇ Been here before
- ◇ Friend or Relative
- ◇ Other (Specify) _____

- ◇ DOG
- ◇ CAT

Animal's Name: _____
Breed: _____
Color: _____
Age: _____

Male _____ Neutered _____ Female _____ Spayed _____

Please check the vaccinations given in the past year: None _____

DOG:	CAT:
Rabies _____	Rabies _____
Distemper _____	FVRCP (Distemper) _____
Parvo _____	Feline Leukemia _____
Corona _____	FIV _____
Bordatella _____	Other _____

When were vaccinations given _____ Where _____
Phone Number _____

Is your dog on Heartworm Prevention? Yes _____ No _____ Type: _____
Is your animal allergic to any medications? Yes _____ No _____ List : _____
Will your animal be boarding anywhere? Yes _____ No _____ Where: _____

Please sign stating that you are responsible for all charges that occur on this account and that to your knowledge all this information is correct.

X _____ Date : _____