Spalding Animal ClinicNew Client Form

Home Phone: (City.		late	zip		
Would you like to receive text reminders for appointments? YES NO How did you hear about us? Newspaper Television Hospital Sign Radio Personal Recommendation (Whom can we thank?				Cell	: ()	_
Personal Recommendation	Would you like to receive	e text reminders	for appointment	ts? _ YES _ N	NO	
Name: Age/Birthday:	Personal Recommenda	ition (Whom	can we thank?			
Name:						
Species (cat, dog, etc.) Breed Color Weight Male Female Spayed/Neutered? yes no Does your pet bite? yes no Does your pet have allergies? yes no Has your pet ever had a reaction to vaccines or medications? yes no If yes, what? Vaccination History (Date and type of last vaccinations) Please check any symptoms or problems that you have noticed about your pet. Behavioral Problems Lack of Appetite Sneezing Bleeding Gums Limping Thirst and/or Coughing Scooting Vomiting Diarrhea Scratching Weakness Eye Bulging or Seems Depressed Other Bloodshot Shaking Head Gagging Pet's current medications Describe your pet's diet Authorization I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. My pet's picture may be used on social media accounts of Spalding Animal Clinic	•		Age/Birthday:			
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Method of Payment |_|Cash |_|Check |_|MasterCard |_|Visa |_|Other _____