SHELBURNE VETERINARY HOSPITAL

NEW CLIENT INFORMATION

Welcome to Shelburne Veterinary Hospital! Please help us provide your pet(s) with the best care possible by completing this form.

Today's Date: ___/___/_____

First Name: _____ Last Name: _____
Street Address:_____
City:_____ State:_____ Zip:_____

Phone Number(s):
Please list in order of preference
1. ( ) ____-_____ Home ☐ Cell ☐ Work☐
2. ( ) ____-_____ Home ☐ Cell ☐ Work☐
3. ( ) ____-_____ Home ☐ Cell ☐ Work☐

Email Address: _____

Please check preferred method of contact: Postcard ☐ or Email ☐

Additional contact(s) authorized to make treatment decisions:
First/Last Name(s): _____
Phone Number(s): (_____)_____

How did you hear about Shelburne Veterinary Hospital?
Online Research ☐ Social Media ☐ Radio ☐ Print Ads ☐ Friend/Family ☐
(If referred, name of person who referred you so we can thank them: _____)

Reason for Visit: _____
Previous Vet: _____ *Date of Last Visit:* _____

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PATIENT INFORMATION

Pet 1

Patient Name:_____ Age/Birthday: _____

Species:_____ Breed:_____ Color: _____

Sex: _____ Neutered/Spayed: Yes: ☐ No: ☐

Does your pet have allergies? Yes: ☐ _____ No: ☐
Has your pet ever had a reaction to vaccines or medications?
Yes: ☐ _____ No: ☐

Does your pet have any long term medical problems?
Yes: ☐ _____ No: ☐

Is your pet on any medications (including over-the-counter and supplements)?
Yes: ☐ _____ No: ☐

Is there anything else we should know about your pet? _____

Pet 2

Patient Name:_____ Age/Birthday: _____

Species:_____ Breed:_____ Color: _____

Sex: _____ Neutered/Spayed: Yes: ☐ No: ☐

Does your pet have allergies? Yes: ☐ _____ No: ☐

Has your pet ever had a reaction to vaccines or medications?
Yes: ☐ _____ No: ☐

Does your pet have any long term medical problems?
Yes: ☐ _____ No: ☐

Is your pet on any medications (including over-the-counter and supplements)?
Yes: ☐ _____ No: ☐

Is there anything else we should know about your pet? _____

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BY SIGNING BELOW, I UNDERSTAND THE FOLLOWING:

It is my veterinarian's recommendation that my pet(s) undergo annual blood work.

It is my veterinarian's recommendation that my pet(s) be tested annually for Anaplasmosis, Lyme, Leptospirosis, and Heartworm disease.

When medications are used on a chronic basis for the treatment of my pet(s) that it is necessary to routinely monitor blood samples to make certain that the medications are not causing deleterious effects to my pet(s) health. These drugs include but are not limited to: NSAIDs, Glucocorticoids (steroids) and/or Opioids.

I HEREBY AUTHORIZE the veterinarian(s) to examine, prescribe for, and/or treat the above described pet(s).

I assume responsibility for all charges incurred in the care and treatment of the above described animal(s). I understand that payment is expected at the time of service, or pick-up.

I also understand that these charges will be paid at the time of service or at the time of releasing my pet(s) to me.

I authorize Shelburne Veterinary Hospital to use my pet(s) image on website and/or social media.

Owner/Agent Signature _____ *Date:* _____