DWIGHT VETERINARY CLINIC

815-584-2732 305 S. Old Route 66 | Dwight, IL 60420 dwightvet.com

INTERNAL USE ONLY : Client ID_____
☐ Scanned ☐ Welcome ☐ Previous Records __Initials

NEW CLIENT FORM

CLIENT/OWNER INFORMATION: **TODAY'S DATE ____/_____/_____**

Name: _____ Birthdate ____/_____/_____

Home Phone: (____) _____ Cell Phone: (____) _____ Best contact number: ☐Home ☐Cell

Mailing Address: _____

City: _____ State: _____ Zip:_____ County: _____

Email Address: _____ Driver's License: _____

Employer: _____ Work Phone: (____) _____

Spouse/Co-Owner Name: _____ Spouse Phone: (___) _____

How did you hear about us? ☐Radio ☐Sign ☐Newspaper ☐Internet ☐Yellow Pages ☐Yelp ☐Facebook

☐Employee _____ ☐Other Hospital/Doctor _____

☐Friend – Name _____ ☐Other _____

Payment Preference: ☐Cash ☐Check ☐Debit ☐Credit (Am.Express, Discover, Mastercard, Visa) ☐CareCredit

PET INFORMATION:

Name: _____ Species: ☐Dog ☐Cat ☐ Other _____

Date of Birth:_____/_____/_____ or Approximate Age:_____

Breed:_____ Color:_____ Sex: ☐Male ☐Female Spayed/Neutered: ☐Yes ☐No

Microchipped: ☐Yes ☐No Number:_____ Does your pet **have** Pet Insurance: ☐Yes ☐No

Has your pet been vaccinated or tested for:

Dog: Rabies (1 yr or 3 yr) ☐Yes ☐No Date_____
Distemper (DA2PP) ☐Yes ☐No Date_____
Heartworm ☐Yes ☐No Date_____
Intestinal Parasites ☐Yes ☐No Date_____
Other: _____

Cat: Rabies (1 yr or 3 yr) ☐Yes ☐No Date_____
Distemper (FVRCP) ☐Yes ☐No Date_____
Leukemia ☐Yes ☐No Date_____
Intestinal Parasites ☐Yes ☐No Date_____
Other: _____

Vaccinated Where?_____ Phone: (____) _____

Any significant medical history or known allergies? _____

Any medications your pet is currently on? _____

_____

Additional Pets:

Name: _____ Species: ☐Dog ☐Cat ☐ Other _____

Date of Birth:_____/_____/_____ or Approximate Age:_____

Breed:_____ Color:_____ Sex: ☐Male ☐Female Spayed/Neutered: ☐Yes ☐No

Microchipped: ☐Yes ☐No Number:_____ Does your pet **have** Pet Insurance: ☐Yes ☐No

Any significant medical history or known allergies? _____

Any medications your pet is currently on? _____

Name: _____ Species: ☐Dog ☐Cat ☐ Other _____

Date of Birth:_____/_____/_____ or Approximate Age:_____

Breed:_____ Color:_____ Sex: ☐Male ☐Female Spayed/Neutered: ☐Yes ☐No

Microchipped: ☐Yes ☐No Number:_____ Does your pet **have** Pet Insurance: ☐Yes ☐No

Any significant medical history or known allergies? _____

Any medications your pet is currently on? _____

I grant Dwight Veterinary Clinic permission to use, reuse, publish, and broadcast in any and all social media photographs, radiographs or video footage recorded at the hospital of me and/or my pet, in which I may be included with others. I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet(s). I assume responsibility for all charges accrued in the care of this animal presented by me or my agents. I also understand that the charges will be paid in full at the time of services rendered or at release and that a deposit may be required for surgical treatment or hospitalization. I understand that I am responsible for a returned check fee of $25. I agree to pay for the reasonable costs of collection, attorney fees, and court costs in the event that collection efforts become necessary.

Signature: _____ **Date:** _____/_____/_____