



DWIGHT VETERINARY CLINIC

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

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) <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	Cat: Rabies (1 yr or 3 yr) <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____
Distemper (DA2PP) <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	Distemper (FVRCP) <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____
Heartworm <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____
Intestinal Parasites <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	Intestinal Parasites <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____
Other: _____	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: ____/____/____