DEL MAR HEIGHTS
VETERINARY HOSPITAL

NEW CLIENT FORM

PLEASE PRINT

Date:

Client's Name: _____ (FIRST & LAST)

Cell: _____ (PHONE)

Email: _____

Home: _____ (PHONE)

Spouse/Co-Owner: _____ (FIRST & LAST)

Cell: _____ (PHONE)

Email: _____

Home: _____ (PHONE)

Address: _____ (STREET) (CITY) (STATE) (ZIP CODE)

How did you find out about our hospital? If you were referred by someone, who should we thank?

_____

Pet's Name: _____

Species: _____ (DOG, CAT, ETC.)

Color/Markings: _____

Breed: _____

Age/Date of Birth: _____

Food Brand: _____

Vaccines (mark all that apply):

- ○ Rabies
- ○ Distemper
- ○ Parvo (dogs only)
- ○ Bordetella (dogs only)

Sex (mark all that apply):

- ○ Male
- ○ Neutered
- ○ Female
- ○ Spayed

Date of last fecal test for worms: _____

I give permission for Del Mar Heights Veterinary Hospital to share photographs or case specific information about my pet in all media (including promotion, advertising, sale, publicizing, and general marketing of Del Mar Heights Veterinary Hospital). *

- ○ Yes
- ○ No

- ○ My pet and I would appreciate assistance when getting in and out of the car.
- ○ My pet tends to not play well with others. If possible, please have an exam room ready so we do not have to wait in the lobby.

Professional Fees are due at the time services are rendered. For your convenience, we accept the following payments: Visa, Mastercard, American Express, Discover, CareCredit and Cash. An estimated cost of medical treatment will be provided for your visit. All fees are due upon release of patient. By signing below, I attest I am at least 18 years old and financially responsible for the pet(s) listed above.

Signature: _____