

LANCASTER ANIMAL CLINIC

CLIENT INFORMATION

DATE: _____

First Name: _____ Last Name _____

Address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ Cell: _____

Place of employment: _____ Work phone: _____

If you wish for someone else to have the right to make medical and financial decisions regarding your pet(s), please fill in the information under Co-owner

Co-owner: _____

Address if different from above: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ Cell: _____ Work: _____

How did you hear about us? Internet Yellow Pages Hospital Sign Referral by _____

WHY WE NEED YOUR E-MAIL ADDRESS

We do not sell emails to outside interests. Emails are a growing part of our practice to better provide you with information and services. They may include:

- Reminder notices for vaccines and annual exam
- Appointment reminders
- Pre-anesthesia instructions
- Post-procedural instructions
- New-client welcome information
- Practice new and announcements

Email address of owner: _____ co-owner: _____

I do not have email or I decline to receive communications via email. Check box:

OFFICE USE ONLY Info verified as accurate on (date)/(initials)

NEW PATIENT INFORMATION

DATE: _____

Pet's Name: _____

Species: Dog Cat Bird Reptile Rodent Skunk Other _____

Breed: _____ Date of birth: _____

Color: _____

Gender: Male Neutered Male Female Spayed Female

Previous Veterinarian: _____ Date of last vaccine: _____

Comments: _____

Pet's Name: _____

Species: Dog Cat Bird Reptile Rodent Skunk Other _____

Breed: _____ Date of birth: _____

Color: _____

Gender: Male Neutered Male Female Spayed Female

Previous Veterinarian: _____ Date of last vaccine: _____

Comments: _____

Pet's Name: _____

Species: Dog Cat Bird Reptile Rodent Skunk Other _____

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Gender: Male Neutered Male Female Spayed Female

Previous Veterinarian: _____ Date of last vaccine: _____

Comments: _____