AKRON BARBERTON VETERINARY CLINIC NEW CLIENT INFORMATION

Name of person responsible for bill (must be 18 years or older) ______________________________

Spouse/Other______________________________ Home Phone Number ______________________

Address______________________________ Email Address ______________________

City______________________________ State__________ Zip Code____________

Employer ______________________________ Work Phone Number ______________________

Spouse/Other Employer ______________________________ Work Phone Number ______________________

Method of payment: Cash____ Visa____ MC____ Discover____ CareCredit____ (*NO CHECKS ACCEPTED*)

Please notify the technician or Doctor of any budget limitations you may have for the treatment of your pet.

Patient Name______________________________ Species: Canine / Feline / Other

Breed______________________________ Gender: Male / Female

Color____________________ Markings______________________________

Birth Date Mo.__________ Year__________ Neutered: Yes / No

Has your pet been vaccinated for these diseases? When was the last date of your vaccines and where given?

Dogs:	Distemper/Parvo/Corona➔	Yes / No	Date__________	Where____________________
	Rabies➔	Yes / No	Date__________	Where____________________
Cats:	Distemper➔	Yes / No	Date__________	Where____________________
	Feline Leukemia➔	Yes / No	Date__________	Where____________________
	Rabies➔	Yes / No	Date__________	Where____________________

Are you currently giving your pet medications? Yes / No

If yes, please list ____

Please list information for any additional pets on the back of this form.

How did you first hear of our hospital?

____Individual; name of someone we can thank______________________________

____ Yellow Pages ____ Hospital Sign ____ Newspaper ____ Other ______________________

I assume responsibility for all charges incurred in the care of the animal(s) I have presented for treatment. I understand that all charges must be paid at the time of release and that a deposit may be required for surgical treatment. I also understand that all medical records, lab results, x-rays, and reports for my animal(s) become the property of Orrville Veterinary Clinic, Inc.

Signature ______________________________ Date ______________________

Patient Name______________________________ Species: Canine / Feline / Other

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For the excellence you've come to expect…we've grown to provide.

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Rabies➔ Yes / No Date___________ Where________________________

Cats: Distemper➔ Yes / No Date___________ Where________________________

Feline Leukemia➔ Yes / No Date___________ Where________________________

Rabies➔ Yes / No Date___________ Where________________________

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Rabies➔ Yes / No Date___________ Where________________________

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If yes, please list ____