NEW CLIENT INFORMATION

Client Name & Spouse/Other _____

Primary Phone Number_____ Cell Phone _____

Spouse/Other Number_____ Email Address _____

Address_____ City_____ State ____ Zip Code_____

Employer _____ Work Phone Number _____

Method of payment: Cash____ Check____ Visa____ MC____ Discover____ CareCredit____

Patient Name_____

Species: Canine / Feline / Other Gender: Male / Female Neutered: Yes / No

Breed_____

Color_____ Markings_____

Birth Date Mo._____ Year_____

Has your pet been vaccinated? Veterinary facility where pet received vaccinations: _____

Please list any medications that your pet is currently receiving (including supplements and over the counter medications):
_____

How did you hear about us?
Individual; name of someone we can thank: _____
Internet Search _____ Social Media _____ Hospital Sign _____ Other _____

PHOTO RELEASE

I give consent to Veterinary Wellness Partners to use my pets' names, biographical information, photographs, stories, videos, and/or testimonial for educational and/or recreational purposes. I understand that I can revoke this consent in writing at any time. I am 18 years of age or older and I am the owner/agent of the listed pet(s).
Pet name(s): _____

_____ Yes, I give my consent (please initial)
_____ No, I do not give my consent

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 is required for emergency or surgical treatment. All unpaid account balances are subject to interest at the rate of 18% annually. Collections action and legal proceedings may be utilized to recover any unpaid account balances. I understand that all medical records, lab results, x-rays, and reports for my animal(s) are the property of Orrville Veterinary Clinic, Inc.

Signature _____ Date _____

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

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 _____

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?

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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 _____
