



NEW PATIENT FORM

Owner: _____

First Name

Last Name

Pet's Name: _____

Species (Circle One):

Cat

Dog

Breed: _____ Color: _____ Approx. Age or Date of Birth: _____

Sex (Circle One): Female

Male

Circle if Applicable:

Spayed

Neutered

Microchip Number: _____

Where/When did you acquire your pet? _____

Medical History

What do you feed your pet? _____

Does your pet have any ongoing medical conditions? _____

Please list your pet's current medication(s) _____

Has your pet had any surgeries (besides spay/neuter) or dental work (specify type and dates) _____

Does your pet have any allergies to vaccinations, medications, food, fleas, etc.? _____

Are there any special considerations regarding your pet (Dog reactive, prefers female staff/handlers, etc)? _____

Pets First Veterinary Clinic offers an integrative approach to medicine by combining Alternative and Western medicine. Alternative medicine has been practiced for centuries and is sometimes called Holistic or Complementary Medicine. Many aspects of these two medical disciplines are similar in that they both require a thorough physical exam and diagnostic testing, where appropriate, based on history and exam findings.

Please tell us if you prefer: Alternative Treatment Western Treatment A Combination of Both

I understand that I am at least 18 years of age and financially responsible, for all charges incurred by me. I understand that full payment is required at the time services are provided. If I have any issues with payment today, I will inform Pets First Veterinary Clinic before services are provided. I further, understand that I have the right to request a written estimate for any and all diagnostic tests, procedures and treatments that I elect to have performed by Pets First Veterinary Clinic. By signing below, I am authorizing veterinary care be provided for the above described pet, presented by me or by my directed agent(s) to Pets First Veterinary Clinic. I understand that veterinary care may include, but is not limited to, examination, prescription or administration of medication or medical treatment including surgery. I agree that in the event of nonpayment, I will bear the cost of collection, court costs and reasonable legal fees should such action be required. I agree that a photocopy of this authorization shall be valid as the original.

Signature of Owner or Authorized Agent _____ Date _____