

# Archer Veterinary Clinic

## New Client & New Patient Form

**Client Information**

Date: \_\_\_\_\_

Name \_\_\_\_\_ Spouse/Secondary Owner \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County: \_\_\_\_\_

Primary number \_\_\_\_\_ Secondary number \_\_\_\_\_

Additional phone numbers \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Referred by: \_\_\_\_\_

**All fees are due at the time services are rendered. Written estimates are provided upon request.**

We accept the following: Cash Check/Debit



How did you hear about us?  Personal Recommendation (Whom may we thank) \_\_\_\_\_

Website  Hospital Sign / Drove By  Yellow Pages  Other (please list) \_\_\_\_\_

Patient Info	Pet Info #1	Pet Info #2	Pet Info #3	Pet Info #4
Name				
Breed				
Date of Birth				
Color				
Male/Female : Neutered?				
<b>HISTORY – CANINE</b>	<b>Date Performed</b>	<b>Date Performed</b>	<b>Date Performed</b>	<b>Date Performed</b>
Rabies Vaccine				
DAPP Vaccine				
Bordetella (Kennel Cough)				
Leptospirosis Vaccine				
Lyme Disease Vaccine				
Influenza Vaccine				
Last Heartworm Test				
Type of Prevention Used				
<b>HISTORY – FELINE</b>	<b>Date Performed</b>	<b>Date Performed</b>	<b>Date Performed</b>	<b>Date Performed</b>
Rabies Vaccine				
FVRCP Vaccine				
Leukemia Vaccine				
Leukemia / FIP Test				

Our pet is a:  Member of the family  Service Animal  Foster Animal  Show Animal

Any previous illnesses or surgeries? \_\_\_\_\_

Any allergies to vaccines or medications? \_\_\_\_\_

Is your pet on any special diet or medication? \_\_\_\_\_

Please list the names of any other family members/person(s) that we may release medical information to:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Owner/Agent for Pet

\_\_\_\_\_  
Date