



PLumsted Animal Hospital, LLC

NEW CLIENT FORM

Owner's Name: _____

Spouse Name: _____

Phone Number: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Street Address: _____

City: _____ ST: _____ Zip: _____ County: _____

Emergency Contact: _____ Number: _____

How did you find us: Phone Book Advertisement Facebook Internet

Friend: _____ Other: _____

Pet Information:

**Please present current vaccination records to the front office staff upon initial visit. For your convenience you may have your previous hospital fax your records to (609) 286-2798.

Pet :

Species (Circle one): Dog Cat Other: _____

Name: _____ Breed: _____ Color: _____

Sex (Circle one): Male Female Birthday (mm/dd/yyyy): _____

Weight: _____ Spayed/Neutered (Circle one): Yes No

Previous Animal Hospital: _____

Pet :

Species (Circle one): Dog Cat Other: _____

Name: _____ Breed: _____ Color: _____

Sex (Circle one): Male Female Birthday (mm/dd/yyyy): _____

Weight: _____ Spayed/Neutered (Circle one): Yes No

Previous Animal Hospital: _____

Continue on back

Pet :

Species (Circle one): Dog Cat Other: _____

Name: _____ Breed: _____ Color: _____

Sex (Circle one): Male Female Birthday (mm/dd/yyyy): _____

Weight: _____ Spayed/Neutered (Circle one): Yes No

Previous Animal Hospital: _____

Pet :

Species (Circle one): Dog Cat Other: _____

Name: _____ Breed: _____ Color: _____

Sex (Circle one): Male Female Birthday (mm/dd/yyyy): _____

Weight: _____ Spayed/Neutered (Circle one): Yes No

Previous Animal Hospital: _____

Pet :

Species (Circle one): Dog Cat Other: _____

Name: _____ Breed: _____ Color: _____

Sex (Circle one): Male Female Birthday (mm/dd/yyyy): _____

Weight: _____ Spayed/Neutered (Circle one): Yes No

Previous Animal Hospital: _____

PAYMENT IS REQUIRED WHEN SERVICES ARE PERFORMED

Please Sign the Following Authorization for Treatment

As owner/guardian, I hereby authorize the staff at Plumsted Animal Hospital to render any treatment that is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment.

Signature: _____ Date: _____