

Pet Medical Center of Las Vegas
New Client Form

CLIENT INFORMATION

Date _____

Last name _____ First _____

Name _____ Title _____

Street Address _____ Apt # _____

City _____ State _____

Zip Code _____

Home Phone (____) _____ Work Phone

(____) _____

Spouse's Name _____ Fax Number

(____) _____

Cell Phone _____ Spouse's Cell

(____) _____

How did you become aware of our clinic? Sign Yellow Pages Website Mailer

Personal Recommendation (Whom may we thank?)

E-mail Address _____ Preferred doctor (if any)

SS# _____ DL# _____

Employer _____

PET INFORMATION

Pet #1 Name _____ Sex _____

Spayed/Neutered? _____

Birth Date or Approximate Age _____ Rabies Tag

Breed _____ Microchip # _____

Color _____

Dog Cat Allergies or Medical

Conditions _____

Pet #2 Name _____ Sex _____

Spayed/Neutered? _____

Birth Date or Approximate Age _____ Rabies Tag

Breed _____ Microchip # _____

Color _____

Dog Cat Allergies or Medical

Conditions _____

Pet #3 Name _____ Sex _____

Spayed/Neutered? _____

Birth Date or Approximate Age _____ Rabies Tag

Breed _____ Microchip # _____

Color _____

Dog Cat Allergies or Medical

Conditions _____

Our pet is a Member of our family Child's pet Backyard pet

Do you travel with your pet? Yes No

I understand that I am responsible for payment for all services rendered at the time they are received

Signature _____

Date _____