Blue Starr Animal Hospital

New Client Form

Thank you for giving us the opportunity to care for your beloved pet(s).

Client Information:

Name: _____ Spouse Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ Spouse's Number: (____) _____

☐ Cell Phone ☐ Home Phone

Email Address: _____

Place of Employment: _____ Work Number: (____) _____

How did you hear about us?

Internet Street Sign Friend: _____ Other: _____

Patient Information:

	Pet # 1	Pet # 2	Pet # 3
Name			
Breed			
Color			
DOB or Age			
Sex			
Are They Spayed or Neutered?			

If you have more than 3 pets, please use the back side of this paper to fill out information.

Patient Medical Records:

Are we allowed to contact your previous veterinary clinic to obtain medical records of your pet(s)? ☐ YES ☐ NO ☐ I will provide my pet(s) records.

If yes; previous clinics name: _____

Previous Clinic's Phone Number: (_____) _____

Is your pet(s) allergic to any medications or vaccines? _____

Payment is due at the time services are rendered; Thank you.

Signature: _____ **Date:** _____

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Patient Information Continued:

	Pet # 4	Pet # 5	Pet # 6
Name			
Breed			
Color			
DOB or Age			
Sex			
Spayed or Neutered?			

	Pet # 7	Pet # 8	Pet # 9
Name			
Breed			
Color			
DOB or Age			
Sex			
Spayed or Neutered?			