Animal Hospital of South Gorham
New Client Information

Date_____ Acct.#_____

Owner's Name_____**Co-Owner**_____

Address_____ City/State_____Zip_____

Primary Phone:_____ Secondary Phone(s):_____

Email Address:_____

Employer Name:_____Work Phone: _____

****HOSPITAL POLICY REQUIRES SOCIAL SECURITY #, DRIVERS LICENSE # AND BIRTHDATE IF YOU ARE WRITING A CHECK****

Owner S.S.N._____Drivers License #_____DOB_____

Co-Owner S.S.N._____Drivers License #_____DOB_____

Pet Health Information/History

Pets Name_____ Date Of Birth_____

____Dog ____Cat ____Bird ____Other Sex: _____Male_____Neutered: YES or NO

Breed/Species_____ _____Female___Spayed: YES or NO

Color_____ _____Unknown

Markings _____ Microchip# _____

Vaccination History (Please circle vaccines that have been given):

Dog: DHPP(Distemper) Lepto Rabies Kennel Cough Lyme Heartworm Test

Cat: FVRCP(Distemper) Rabies Feline Leukemia FeLV/FIV Test

Ferret: Distemper Rabies

****ALL DOGS,CATS,FERRETS,AND GOATS MUST BE RABIES VACCINATED FOR TREATMENT****

Date of last vaccines: _____

What is your pet's diet/amount fed?: _____

Previous health issues/Current medications: _____

_____

Any other pets in household?: _____

How did you hear of us?: _____

Who is your pet's medical insurance provider? _____

Do we have consent to post photos of your pet via social media (Facebook/Instagram/Website)? Circle: **YES NO**

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of services.

Signature of Owner: _____ Date: _____