



All Creatures Veterinary Care Center

NEW PATIENT FORM

Date _____

CLIENT INFORMATION

Name _____

Spouse/Secondary Name (if applicable) _____

Mailing Address _____

City _____ State _____ Zip _____

Home Telephone () _____ Cell Phone () _____

Email Address _____

PATIENT INFORMATION

Name _____

Species Dog Cat Small Mammal Bird Reptile Other _____

Breed _____

Sex Male or Neutered Male Female or Spayed Female

Date of Birth _____ Color/Markings _____

Are you this pet's owner? Yes No

VACCINE HISTORY (Please provide pet's vaccine history and/or copy of prior medical records.)

Canine

Date Performed

Feline

Date Performed

Rabies _____

Rabies _____

Distemper _____

Distemper _____

Bordatella _____

Leukemia _____

Heartworm Test _____

FELV/FIV Test _____

Fecal Test _____

Fecal Test _____

ADDITIONAL INFORMATION (If you will be paying by check or credit card, we will need some additional information. This information will remain confidential. Please complete the following:

Driver's License (required) _____ State _____

Social Security Number (required) _____

Employer's Name & Address _____

HOW DID YOU HEAR ABOUT ALL CREATURES VETERINARY CARE CENTER?

- Referred by my Veterinarian
- Referred by a Friend/Family
- Internet
- Yellow Pages

(Please provide name so we may thank them)

Other (Please specify) _____

PAYMENT OPTIONS

All bills must be paid when services are rendered. We do not bill. We accept all major credit cards including Care Credit. Personal checks are welcome when accompanied by a driver's license. If you have any questions regarding your payment today, please discuss it with a receptionist before seeing the doctor. Thank you.