



NEW CLIENT FORM

*Thank you for giving Hoffman Animal Hospital the opportunity to care for your pet(s).
So that we may become better acquainted, please complete the following:*

CLIENT INFORMATION

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Work # _____ Cell # _____ Email _____

Spouse's Name _____ Spouse's Work # _____ Spouse's Cell # _____

Best number to reach you _____ Active Military? Yes _____ No _____ Branch _____

How did you become aware of our clinic? Phone Book HAH Website Facebook Internet
 Open House SPCA SPCA Walk Strawberry Festival Cape Fun Run Community Event
 Referral Vet Drove By Friend Other _____

Personal Recommendation: (whom may we thank?) _____

Name & Phone # of previous Veterinarian _____

PATIENT INFORMATION	PET #1	PET #2	PET #3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX / SPAYED OR NEUTERED?			

MEDIA RELEASE		
FACEBOOK	YES	NO
TWITTER/ HAH BLOG	YES	NO
MARKETING BROCHURES	YES	NO
EDUCATIONAL BROCHURES	YES	NO

* I authorize the staff of Hoffman Animal Hospital to release portions of my pet(s) medical history and record, including personal recollections, radiographs, photographs, videotape images, or other images to the above media entities.

OUR PET(s) is: Member of Our family Child's Pet Backyard Pet

Other Pets _____

Any previous serious illness or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

Would you like to be present during treatment of your pet? YES NO

**ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED AND I AGREE TO PAY THE BALANCE IN FULL.
IF NOT PAID IN FULL, I AGREE TO PAY ALL COSTS ASSOCIATED WITH COLLECTION.**

SIGNATURE: _____