



# New Client Form

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

**WE'RE "HEAR" FOR YOU!**

## CLIENT INFORMATION

Owner's Name \_\_\_\_\_

Co-Owner's Name \_\_\_\_\_ Children (First Names): \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_ Other Phone Number \_\_\_\_\_

E-Mail Address \_\_\_\_\_

**PLEASE INDICATE HOW YOU BECAME AWARE OF OUR HOSPITAL:**

1.  Personal Recommendation (whom may we thank?) \_\_\_\_\_
2.  Internet
3.  I was a previous client
4.  Drove-by/sign
5.  Yellow Pages

**ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH/CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, AND CARE CREDIT.**

PET INFORMATION					
PET #1		PET #2		PET #3	
Name		Name		Name	
Breed		Breed		Breed	
Birthday		Birthday		Birthday	
Color		Color		Color	
Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Spayed <input type="checkbox"/> Neutered	Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Spayed <input type="checkbox"/> Neutered	Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Spayed <input type="checkbox"/> Neutered

NAME/PHONE NUMBER OF PREVIOUS VETERINARY HOSPITAL: \_\_\_\_\_

Please fax 203-975-1653 or email (info@mybhph.com) all previous medical history, vaccination records and any medications your pet is taking. In order to provide the best possible care for your pet, records MUST be received 48 hours prior to your appointment for our doctors review. If not received, your appointment may be rescheduled.