

West Woodward Animal Clinic

915, West 9 Mile Road, Ferndale, MI 48220

Telephone: (248)-414-9700

Fax: (248)-414-9702

NEW CLIENT/PATIENT FORM

Owner Information

Last Name: _____ First Name: _____

Street Address: _____ City: _____ Zip Code: _____

Phone Number(s): Home: _____ Cell: _____ Work: _____

Spouse/Significant Other: Last Name: _____ First Name: _____

E-Mail Address: _____ Source of Referral: _____

Patient(Pet) Information

(1) Pet Name: _____ Dog: ___ Cat: ___ Exotic: ___ Other: _____

Breed: _____ Color: _____ Sex: **Male** or **Female**

Sex (Continued): **Spayed** or **Neutered** Date of Birth: _____

Any Known Allergies: **No** If **Yes**, please provide specifics: _____

—

(2) Pet Name: _____ Dog: ___ Cat: ___ Exotic: ___ Other: _____

Breed: _____ Color: _____ Sex: **Male** or **Female**

Sex (Continued): **Spayed** or **Neutered** Date of Birth: _____

Any Known Allergies: **No** If **Yes**, please provide specifics: _____

—

Please Note: Payment is expected when the services are rendered. There is no billing service. No personal checks are accepted for first time clients. Forms of payment include: **Cash, Credit Cards (Visa, MasterCard, Discover), Care Credit Insurance. American Express is NOT** accepted.

I am the true owner of the above-mentioned animal(s) or am acting as an agent of the owner. I fully accept responsibility for and give permission to proceed with any medical/surgical treatment as deemed necessary by the veterinarian.

Signature: _____ Date ____/____/____