South Bend Animal Clinic

3224 Lincoln Way West
South Bend, IN 46628
(574) 232-1459

New Client Form

Welcome! We are glad you have chosen us to care for your pet. To do the best job we can, please provide us with the following information. Thank you!

Owner's Name:____
Spouse's Name:____
Address:____Apt___________________
City:___________________________State:____________________Zip:_________________________
Home Phone #___________________________ Cell Phone #________________________________
Spouse's Cell Phone #___________________________________
Email:____
How did you hear about us?____

Patient #1 Name:_____________________________ Species (dog, cat):_________________________
Breed(s) Specify:____________________________
Age/Birth Date:__________________ Color(s):_________________Sex:____ Neutered? Yes/ No
Previous Veterinarian/Animal Hospital____
Has your pet had any adverse reactions to any medications or vaccinations?___________________
If yes, please list:____
Please list any prior illness/diseases/medications ____
____

Patient #2 Name:_____________________________ Species (dog, cat):_________________________
Breed(s) Specify:____________________________
Age/Birth Date:__________________ Color(s):_________________Sex:____ Neutered? Yes/ No
Previous Veterinarian/Animal Hospital____
Has your pet had any adverse reactions to any medications or vaccinations?___________________
If yes, please list:____
Please list any prior illness/diseases/medications ____
____

Professional Fees are due at the time services are rendered.

The above information is complete and accurate. As owner of the above pet(s), I agree to be responsible for paying all unpaid balances, all service charges and collection fees that may occur concerning the health of my pet(s).

Print Name:____ Date:__________
Signature:____ Date:___________