

New Client Information Form



Date: _____

Owner's Name: Last _____ First _____

Owner's Date of Birth: _____ (necessary for prescription of controlled drugs)

Significant Other: Last _____ First _____

Address: Street _____ Apt. # _____

City _____ Zip Code _____

Phone Number: Home: _____ Cell: _____ Work: _____

E-mail (for your pets' medical records): _____

Who else is authorized to make medical/financial decisions for your pets:

How did you hear about us?

- Google; Yelp; Porter Pet Website; Porter Pet Postcard; Hospital Sign;
 Other: _____ Existing Client: _____

(Tell us if a friend referred you. He/she & you may be entitled to a \$15 credit.)

Pet Information

Pet #1

Name: _____ Species: Dog Cat D.O.B. or Age: _____

Breed: _____ Color: _____ Hair Length: _____

Sex: Male _____, Neutered Male _____, Female _____, Spayed Female _____

Current Medical Conditions: _____

Pet #2

Name: _____ Species: Dog Cat D.O.B. or Age: _____

Breed: _____ Color: _____ Hair Length: _____

Sex: Male _____, Neutered Male _____, Female _____, Spayed Female _____

Current Medical Conditions: _____

**We accept Cash, Visa, MasterCard, American Express, Discover, and Debit. We also accept Care Credit.
WE DO NOT ACCEPT CHECKS.**

Payment is due at the time of service. You may be asked for a deposit when dropping off your pet.

I verify that all of the above information is accurate. Only people listed on this form are authorized to make medical or financial decisions for my pets.

X _____ Date: _____

Thank you for choosing Porter Pet Hospital!

-Drs. Newman, Meyerhoff, Andrietti, and Hu

- Francisco, Annie, LJ, Elizabeth, Teresa, Tomas, Idania, Karla, Gerardo, Danelia, Claudia, Monica, Bryan, & Natalie