OROVILLE
ANIMAL HEALTH CENTER

2420 Meyers Street, Oroville, CA 95966

NEW CLIENT FORM

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

CLIENT INFORMATION

Name _____ Spouse's Name _____

Address_____ City _____ State _____ Zip _____

Phone _____ Spouse's Phone _____ Other Phone_____

E-mail Address_____ DOB(for Rx purposes) _____

How did you become aware of our clinic? ❒ Drove By ❒ Yellow Pages ❒ Previous Client

❒ Personal Recommendation–Whom may we thank? _____

All Fees Are Due At the Time Services Are Rendered

PATIENT INFORMATION

	PET #1	PET #2	PET #3
NAME			
BREED			
AGE	YRS:_____ MO:_____	YRS:_____ MO:_____	YRS:_____ MO:_____
COLOR			
SEX	M ❒ F ❒ SPAYED OR NEUTERED?_____	M ❒ F ❒ SPAYED OR NEUTERED?_____	M ❒ F ❒ SPAYED OR NEUTERED?_____
YOUR **DOG'S** VACCINATION HISTORY			
RABIES			
HDLP PARVO CORONA			
BORDETELLA			
LYMES			
FECAL (STOOL SAMPLE)			
HEARTWORM TEST			
YOUR **CAT'S** VACCINATION HISTORY			
RABIES			
DIST-RHINEO CHLAMYDIA			
LEUKEMIA TEST			
LEUKEMIA VACCINATION			
FECAL (STOOL SAMPLE)			

Any previous serious illness or surgeries?_____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

Revised: 2021