# NEW CLIENT FORM

***Thank you for giving us the opportunity to care for your canine companion(s).***
***To help us become better acquainted with you and your dog(s), please complete the following.***

**OWNER INFORMATION:** **Date** _____

First/Last Name _____ Spouse's Name _____

Address _____ City _____ State _____ ZIP _____

Phone (home) _____ (cell) _____ (work) _____

Employer _____ Email address _____

Spouse's Employer _____ Best time to reach you _____

Spouse's Phone (cell) _____ (work) _____

**How were you referred to our clinic?** Personal recommendation ___ Whom may we thank? _____

Commercial Appeal __ Direct mail___ Internet ___ Yellow Pages____ Drove by ___

**PET INFORMATION:**

| | DOG #1 | DOG #2 | DOG #3 |
|---|---|---|---|
| NAME | | | |
| BREED | | | |
| DATE OF BIRTH / AGE | | | |
| COAT COLOR | | | |
| GENDER: SPAYED/NEUTERED? | | | |
| MICROCHIPPED: YES OR NO | | | |

| DATE OF LAST: | DOG #1 | DOG #2 | DOG #3 |
|---|---|---|---|
| RABIES VACCINE | | | |
| DISTEMPER/PARVO | | | |
| BORDETELLA | | | |
| HEARTWORM TEST | | | |
| HEARTWORM PREVENTION | | | |

| OTHER MEDICAL HISTORY: | DOG #1 | DOG #2 | DOG #3 |
|---|---|---|---|
| MAJOR ILLNESS/SURGERY? | | | |
| SPECIAL DIET? | | | |
| CONTINUAL MEDICATIONS? | | | |
| ALLERGIES? | | | |

**Would you like to be present during treatment of your dog(s)?** Yes_____ No____

As required by Tennessee law, by signing below I authorize Kelsey Canine Medical Center, LLC (KCMC) to release medical information about my dog(s), patient(s) at KCMC.

Signed _____