

Limerick Veterinary Hospital NEW CLIENT FORM

(Please Print Clearly)

Limerick Veterinary Hospital is a complete health and wellness facility devoted to the highest standards of practice aimed at raising and maintaining your animal companion's quality of life. Limerick Veterinary Hospital is accredited by the American Animal Hospital Association (AAHA), assuring you that we provide only the highest quality medical and surgical care to the animals entrusted to us. Our practice is devoted to the care of companion animals, including birds and exotic pets. Thank you for trusting your best friend(s) to us.

In order to open an account with us you must be 18 years of age and provide us with at least one form of identification. Your information will be kept confidential. The driver's license number & social security number **MUST** be that of the primary owner. We also need a copy of your photo ID.

Today's date: _____ LVH Representative: _____ Client ID: _____

OWNER INFORMATION

Last Name:	First:	Middle:	Co-Owner/Spouse Name:	Relationship:
Street address:		Driver's License:		Social Security Number:
P.O. Box:	City:		State:	ZIP Code:
Home Phone: <input type="checkbox"/> Primary	Cell Phone: <input type="checkbox"/> Primary	Work Phone: <input type="checkbox"/> Primary	Co-Owner/Spouse Phone:	

Please indicate which number you would like to be listed as the primary number on your account. Our office will call this number first to contact you.

Is there an individual we may thank for referring you to our hospital? _____
 How did you hear about our hospital? Referral Hospital Sign Yellow Pages Internet

Are you eligible for a senior citizen discount? (65 years of age or older) YES NO

E-mail address _____ @ _____ . _____

Providing us with your e-mail address will allow you FREE online access to your own PET PORTAL. This will allow you to access your account and your pet's records with us. We will not solicit your e-mail address to anyone and will only be used by our office.

PET(S) INFORMATION

(Please give any previous records to the receptionist so we may copy them for our records.)

Pet's Name:	Age/Birth date:	Breed:	Color(s):
Distinguishing Markings:			
Sex:	Spayed/Neutered:	Known Medical Conditions:	Is your pet current on their rabies?
	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

Is your pet micro chipped? YES NO Microchip Number (if known): _____

Second Pet (If the pet is with you to be seen today. If you have more than two pets with you today, notify the receptionist for additional papers.)

Pet's Name:	Age/Birth date:	Breed:	Color(s):
Distinguishing Markings:			
Sex:	Spayed/Neutered:	Known Medical Conditions:	Is your pet current on their rabies?
	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

Is your pet micro chipped? YES NO Microchip Number (if known): _____

The above information is true to the best of my knowledge. I understand that I am financially responsible to pay for all services at the time they are rendered. I also understand the written estimates can be provided to me prior to services being provided to my pet(s).

Owner's Signature: _____

Date: _____