NEW CLIENT FORM

We love new clients! Thank you for considering our hospital as your pet's provider of veterinary services. We are dedicated to maintaining the health of your pet and look forward to many future years together.

General Information:

FIRST NAME	
LAST NAME	
EMAIL	
REFERRAL	
ALTERNATE CONTACT FIRST NAME	
ALTERNATE CONTACT LAST NAME	
ALTERNATE CONTACT EMAIL	

Address Information

HOME STREET ADDRESS	
CITY, STATE, ZIP CODE	
MAILING ADDRESS	
CITY, STATE, ZIP CODE	

Phone Information

PHONE NUMBER	
Do you authorize texting to this number?	
ALTERNATE PHONE NUMBER	
Do you authorize texting to this number?	

Authorization

I hereby authorize Little Veterinary Services and its respective agents to examine, prescribe for, treat, board or hospitalize my pets. I assume responsibility for all charges incurred in the care of my animals. I also understand that these charges will be **paid at the time of service** and that a deposit may be required for treatment.

PRINT NAME	
SIGNATURE	
DATE	