



# New Client/Patient Form

Phone: (315) 253-0240 Fax: (315) 253-3576  
85 Grant Avenue, Auburn, NY 13021

# \_\_\_\_\_  
Office use only

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: (H) (\_\_\_\_) \_\_\_\_\_ (W) (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Alternate contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Pet's Name: \_\_\_\_\_ Date of Birth/Age: \_\_\_\_\_

Feline: \_\_\_\_ Canine: \_\_\_\_ Other: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Sex: Male  Female  Neutered (male)  Spayed (female)

Does your pet have a tattoo ID or a microchip? Yes  No  What is the number? \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_

Is there any past medical history we should be aware of? \_\_\_\_\_

## Vaccination History:

Rabies \_\_\_\_/\_\_\_\_/\_\_\_\_ Was this the first time vaccinated for rabies? Yes  No

Distemper \_\_\_\_/\_\_\_\_/\_\_\_\_ Was this the first time vaccinated for distemper? Yes  No

Feline Leukemia \_\_\_\_/\_\_\_\_/\_\_\_\_ Was this the first time vaccinated for FeLV? Yes  No

## Testing History:

Heartworm tested \_\_\_\_/\_\_\_\_/\_\_\_\_ Is your dog on preventative? Yes  No

Feline Leukemia tested \_\_\_\_/\_\_\_\_/\_\_\_\_ Is your cat FeLV vaccinated? Yes  No

FIV tested \_\_\_\_/\_\_\_\_/\_\_\_\_ Is your cat vaccinated? Yes  No

(feline immunodeficiency virus)

How did you hear about **Brookside Veterinary Clinic**? \_\_\_\_\_

What method payment will you be using today? \_\_\_\_\_