

Welcome to the Castlegar Veterinary Hospital

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

Date: _____

Name: _____ Spouse/Co-Owner's Name: _____

Address: _____ City: _____ Prov.: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

*Please indicate which your primary contact number is by marking the box next to it

E-Mail Address _____ Best Time to Reach You _____

I allow the Castlegar Veterinary Hospital to send me electronic message via their website, Pet Portal, text message, and direct emails from the staff (you may unsubscribe at any time): Yes No

In the event your pet is lost, does Castlegar Veterinary Hospital have your consent to provide your contact information (name and phone number) to anyone that may have found your pet? Yes No

How did you become aware of our hospital? Drove by Yellow Pages Web Site Other _____

Personal Recommendation (*Whom may we thank?*) _____

Can we post your pet's Name and Picture on social media? (No Surname) *Yes No

**If YES, we will provide a Social Media Release form for you to review and sign.

Who is your current Pet Insurance Provider? _____

*Please let us know if you don't have pet Insurance, and we can see if your pet qualifies for a free 30-day Trial

Previous Veterinarian/Hospital _____

Have you provided us with the complete records from previous Veterinarians? Yes No N/A

*Please show any records you have to our receptionist so we may ensure accurate dates in our files.

	PET # 1	PET # 2	PET # 3
Name			
Species (Canine, Feline, etc.)			
Breed			
Date of Birth (age)			
Color			
Gender; spayed or neutered?	Male <input type="checkbox"/> Neutered <input type="checkbox"/> Female <input type="checkbox"/> Spayed <input type="checkbox"/>	Male <input type="checkbox"/> Neutered <input type="checkbox"/> Female <input type="checkbox"/> Spayed <input type="checkbox"/>	Male <input type="checkbox"/> Neutered <input type="checkbox"/> Female <input type="checkbox"/> Spayed <input type="checkbox"/>
Tattoo/Microchip Info			
Parasite Prevention (fleas/ticks/etc.)			

General Information

Any previous serious illness or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diet or medications? _____

Payment Policy: All fees must be **PAID IN FULL** when services rendered. If you are unable to meet our payment policy, please notify us prior to treatment. **We accept VISA, MasterCard, Debit, Cash and Medi-Card**

Client Signature: _____

Date: _____