Chart# ____________ **Date:**________

New Client Information Sheet

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following:

Owner:____
Last First Middle Home Phone

Co-Owner/Spouse: ____
Last First Middle Home Phone

Email Address: ____

Address: ____
Street City State Zip Code County

Owner's Place of Employment: ____
Employer Phone

Co-Owner's/Spouse's Place of Employment: ____
Employer Phone

If necessary, may we call you or the co-owner at work? [ ] Yes [ ] No

Cell Phone Number (Owner) _______________________ Co-Owner's/ Spouses Cell: _______________________

If we cannot reach you, in case of EMERGENCY, who should we call? ___________________________________
Name Phone

[ ] Personal Recommendation—Whom may we thank? ______________________________

Pet # 1	Pet # 2	Pet # 3
Name: ____________________	Name: ____________________	Name: ____________________
Species: ___________________	Species: ___________________	Species: ___________________
Breed: ____________________	Breed: ____________________	Breed: ____________________
DOB: ______________________	DOB: ______________________	DOB: ______________________
Color: _____________________	Color: _____________________	Color: _____________________
Sex: M [ ] F [ ] Spay [ ] Neuter [ ]	Sex: M [ ] F [ ] Spay [ ] Neuter [ ]	Sex: M [ ] F [ ] Spay [ ] Neuter [ ]
Microchip# ________________	Microchip# ________________	Microchip# ________________

Authorization:

I authorize the licensed veterinarians of **Sawyer Lake Veterinary Hospital** (and their designated assistants) to administer such treatment as is needed; perform surgical procedures as deemed necessary; and such additional procedures as are considered therapeutically and/or diagnostically indicated on the basis of findings during the course of evaluation. I consent to the administration of necessary anesthetics. I have read and fully understand the above Authorization for Medical and /or Surgical Treatment. I also certify that no guarantee has been made as to the results that may be obtained. I assume financial responsibility for all charges and consent to the release of medical information.

PAYMENT IN FULL is required at the time service is rendered.

X ____
Signature of owner responsible or responsible agent Date