



NEW CLIENT GET ACQUAINTED FORM

Thank you for giving Highland Animal Hospital the opportunity to care for your pet. Please fill in the appropriate blank information as applicable. This will help ensure that your pet's medical record is accurate.
(Please print.)

Owner Information

Owner's Name: _____

Mailing Address: _____

Primary Phone: _____ Home ☐ Work ☐ Cell ☐

Secondary Phone: _____ Home ☐ Work ☐ Cell ☐

Email Address: _____ Occupation: _____

Secondary Owner's Name (optional): _____

Primary Phone: _____ Home ☐ Work ☐ Cell ☐

Secondary Phone: _____ Home ☐ Work ☐ Cell ☐

PLEASE NOTE: The name(s) listed above are the only people who can authorize treatment for pets; include anyone who has permission to do so. Any individual listed is financially responsible for service authorized by him/her or any other listed parties. Must be over 18 years of age to authorize patient care decisions.

PAYMENT IS DUE AT THE TIME OF SERVICE. WE DO NOT BILL. The following payment methods are accepted:

Cash

Visa/Mastercard/Discover/American Express (both debit and credit cards)



Primary Owner Signature _____

Secondary Owner Signature _____

How did you become aware of Highland Animal Hospital?

☐ Referred by _____

☐ Internet Search

☐ Previous Pets

☐ Other _____

PET INFORMATION

**If you have access to your pet's medical records, please bring them with you to your visit.*

Pet Name: _____ Age: _____ Birth Date: _____

Breed: _____ Color: _____

☐ Male ☐ Female ☐ Spayed ☐ Neutered ☐ Declawed (cats only)

Microchip I.D.? ☐ Yes ☐ No I.D. # _____

Normal Diet: ☐ Wet ☐ Dry Specific Brand: _____

☐ Indoor ☐ Outdoor Other animals at home? ☐ Yes Type/Number _____ ☐ No

Significant medical history: _____

Known allergies, drug or food intolerances: _____

Are your pet's vaccinations current? ☐ Yes ☐ No

Is your pet on heartworm prevention? ☐ Yes ☐ No If yes, what frequency? ☐ Year round ☐ Seasonal



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