

New Patient Form
Pumpkin Hill Veterinary Clinic
585-548-9097

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

Date _____

Owner's Name* _____ Spouse/Other _____

**owner must be 18 years or older*

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email: _____

Is there anyone else authorized to drop off, pick up, or make medical decisions, including euthanasia for your pet(s)? If so, please list:

Name: _____ Name: _____

Name: _____ Name: _____

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Patient Name: \_\_\_\_\_ Species (circle one): Dog Cat Other

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Sex: \_\_\_\_\_ Spayed or Neutered? \_\_\_\_\_ Birth Date: \_\_\_\_\_

Vaccine Dates: (please provide paperwork for our records)

Dog: Rabies \_\_\_\_\_ Distemper/Parvo \_\_\_\_\_ Heartworm Test \_\_\_\_\_

Cat: Rabies \_\_\_\_\_ Distemper \_\_\_\_\_ Leukemia \_\_\_\_\_

Any known allergies? \_\_\_\_\_ Special Diet or Medications? \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Will you continue seeing us for routine visits? \_\_\_\_\_

In signing below, I agree that the above information is true and accurate.

Signature of Owner or Responsible Party \_\_\_\_\_

Printed Name of Owner or Responsible Party \_\_\_\_\_