LAKESIDE ANIMAL CLINIC

Your Other Family Doctor

New Client Check-in Form

Client Name _____

Co-Owner/Significant Other/Relative (can make medical decisions)_____

Address _____

City/St/Zip _____

Main Phone (Preferred Contact Number): _____

Secondary Phones: _____ _____

Email Address*: _____

*We use email as a way to follow up with you regarding your pet's health and answer questions after-hours. We also very occasionally send out important pet health information. No spamming or unsolicited emails will be sent.

Pet Name _____

Age _____

Sex (Circle one) Male Male Neutered Female Female Spayed

Breed _____

Color _____

Species (Circle one) Dog Cat Other_____

Drug Allergies_____

Date of Last Vaccination:

Dogs		**Cats**	
Rabies	_____	Rabies	_____
DHPP	_____	FVRCP	_____
Bordetella	_____	Felv	_____
Leptospirosis	_____	FIP	_____
Canine Influenza	_____		

Payment is due in full at the time services are rendered.

How do you wish to pay for your visit today?

_____ Cash
_____ Credit Card
_____ Debit Card
_____ Care Credit

** Unfortunately, we are no longer able to accept personal checks from new clients.