Heineke Veterinary Hospital

New Client/New Patient Form

U.S. 27 & Orlando Drive
Alexandria, KY 41001
(859) 635-3783

I. Client Information

First Name: _____ **Last Name:** _____ **DL#** _____

Address: _____ _____ _____ _____
Street address *City* *State* *ZIP*

Spouse: _____ **DL#** _____
First & Last Name

Contact Information ( ) - **Circle:** Home ¦ Work ¦ Mobile ¦ Other _____
Primary Phone Number *Best time to reach you*

( ) - **Circle:** Home ¦ Work ¦ Mobile ¦ Other _____
Secondary Phone Number *E-mail Address*

How were you referred to us? ☐ Sign ☐ Phone Book ☐ Company website ☐ Other _____
☐ Online (search engine) ☐ Friend/Relative _____
Name of person who referred you

II. Pet Information - Pet #1

Name: _____ **Gender:** Male ¦ Female **Species:** Dog ¦ Cat ¦ Other _____

Breed: _____ **Color:** _____ **Age:** _____ yrs **Weight:** _____ lbs

Circle one: Neutered ¦ Spayed ¦ Neither ¦ Unknown **Pet obtained from:** _____

Is your pet currently on any medication? Yes ¦ No **If YES, please list medication(s)** _____

Please selct any current symptoms or problems. _____

☐ Behavior problems
☐ Breathing trouble
☐ Coughing/Sneezing/Gagging
☐ Diarrhea
☐ Eyes Bulging/Bloodshot
☐ Lack of Appetite
☐ Limping
☐ Loss of Balance
☐ Scratching/Scootir
☐ Shaking Head
☐ Other (not listed): _____

III. Pet Information - Pet #2

Name: _____ **Gender:** Male ¦ Female **Species:** Dog ¦ Cat ¦ Other _____

Breed: _____ **Color:** _____ **Age:** _____ yrs **Weight:** _____ lbs

Circle one: Neutered ¦ Spayed ¦ Neither ¦ Unknown **Pet obtained from:** _____

Is your pet currently on any medication? Yes ¦ No **If YES, please list medication(s)** _____

Please selct any current symptoms or problems. _____

☐ Behavior problems
☐ Breathing trouble
☐ Coughing/Sneezing/Gagging
☐ Diarrhea
☐ Eyes Bulging/Bloodshot
☐ Lack of Appetite
☐ Limping
☐ Loss of Balance
☐ Scratching/Scooting
☐ Shaking Head
☐ Other (not listed): _____

IV. Authorization

*** I authorize Heineke Veterinary Hospital to release medical information of my pet(s) upon request.** _____
Initial

I authorize my pet(s) to be examined and treated. I take full responsibility of all charges before patient is released, and that a deposit may be required fo rmedical or surgical treatment. I am also aware that there is absolutely no billing.

_____ _____
Signature *Date*

Method of payment: Cash ¦ Check ¦ Visa ¦ Mastercard ¦ Discover Card ¦ American Express ¦ Care Credit