Kehoe Animal Clinic Viera

2305 Vidina Dr. Viera, Fl 32940 (321) 877-1825. Fax (321) 284-8858 info@kehoeanimalclinic.com

New Client Information Form

Thank you for giving us the opportunity to care for your pet. Our goal is to provide compassionate and thorough healthcare through education and advanced medical care. You and your pet are our highest priority. We value your commitment to their health and well-being.

In order that we may better serve you, please complete the following:

First Name: (Ms. Mrs. Mr. Dr.) _____ Last Name: _____

2nd Person: (Ms. Mrs. Mr. Dr.) _____ Last Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone#: _____ Name: _____ Cell Home Work (circle one)

Phone#: _____ Name: _____ Cell Home Work (circle one)

Active Military

Email: _____ 2nd Email: _____

☐

Pet's Name: _____ Dog or Cat Breed: _____

Male__ Female__ Spayed/Neutered? Y N Birth Date or Age: _____ Color: _____

Where Obtained? Pet Store__ Shelter__ Breeder__ Friend/Neighbor__ Other_____

Does your pet take any medications? _____

Date of last veterinary visit: _____ Name of last Veterinary Clinic: _____

Name of last Veterinarian: _____ Phone of last Veterinarian: _____

Please initial: _____ I hereby authorize Kehoe Animal Clinic to request previous medical care records from any/all previous providers.

Please initial: _____ I hereby give Kehoe Animal Clinic permission to post photos of my pet(s) on their social media outlets

How did you hear about Kehoe Animal Clinic?

Sign / Drive by ____ Web Site ____ Personal Recommendation ____

Who may we thank for a recommendation? _____

ALL FEES ARE DUE AT THE TIME THE SERVICES ARE RENDERED.

Please review and sign financial policy: I authorize treatment of my pet by the staff and doctors of Kehoe Animal Clinic. I agree to pay fees for services rendered at the time the patient is discharged from the clinic or the service is otherwise terminated. I authorize Kehoe Animal Clinic to release medical records for any/all of my pets when requested by a veterinarian. I confirm that I am at least 18 years of age.**This practice requires a 24 hour notice for appointment cancellation. Any appointment missed and not previously canceled will be documented and if it happens more than three times, could result in a possible discharge from the practice. Any appointment not canceled within 24 hours of the appointment's date will be billed to the client in the amount of the exam fee.**

_____ _____

Client Signature Date

TO ENTER **ADDITIONAL PET(S)** INFORMATION PLEASE TURN THIS PAGE OVER

ADDITIONAL PETS

Pet's Name: ________________________ Dog or Cat Breed: _____________________________

Male__ Female__ Spayed/Neutered? Y N Birth Date or Age: _____________ Color: ___________

Where Obtained? Pet Store__ Shelter__ Breeder__ Friend/Neighbor__ Other________________

Does your pet take any medications? ____

Date of last veterinary visit: ______________ Name of last Veterinary Clinic: _______________________

Name of last Veterinarian: _______________________Phone of last Veterinarian: ____________________

Please initial: _____ I hereby authorize Kehoe Animal Clinic to request previous medical care records from any/all previous providers.

Pet's Name: ______________________ Dog or Cat Breed: _____________________________

Male__ Female__ Spayed/Neutered? Y N Birth Date or Age: _____________ Color: ___________

Where Obtained? Pet Store__ Shelter__ Breeder__ Friend/Neighbor__ Other________________

Does your pet take any medications? ____

Date of last veterinary visit: ______________ Name of last Veterinary Clinic: _______________________

Name of last Veterinarian: _______________________Phone of last Veterinarian: ____________________

Please initial: _____ I hereby authorize Kehoe Animal Clinic to request previous medical care records from any/all previous providers.

Pet's Name: ________________________ Dog or Cat Breed: _____________________________

Male__ Female__ Spayed/Neutered? Y N Birth Date or Age: _____________ Color: ___________

Where Obtained? Pet Store__ Shelter__ Breeder__ Friend/Neighbor__ Other________________

Does your pet take any medications? ____

Date of last veterinary visit: ______________ Name of last Veterinary Clinic: _______________________

Name of last Veterinarian: _______________________Phone of last Veterinarian: ____________________

Please initial: _____ I hereby authorize Kehoe Animal Clinic to request previous medical care records from any/all previous providers.

___________________________________ ___________________

Client Signature Date