central animal hospital (250) 549-0402

Client Information Form

Please fill out the following form and bring with you to your first appointment.

Date: _____

Owner Information

Last Name: _____ First Name_____ Middle Name_____
Other Names on Account: _____
Email Address: _____Driver's Lic #:_____
Mailing Address: _____
City: _____ Province: _____ Postal Code: _____
Street Address (if different from above): _____
Phone: (H) _____ (W) _____ Cell _____
Employer: _____
Employer Address: _____
City: _____ Province: _____ Postal Code: _____
Previous veterinary hospital (if transferring): _____

Pet #1 Information

Name of Pet: _____
Canine Feline Other _____
Breed: _____ Male Female
Color: _____ Neutered Spayed
Date of Birth: _____ Age: _____ Is your pet micro chipped? Yes No
Do you have Pet Insurance for this pet? Yes No If yes, what type?_____
Is your pet currently taking medication: Yes No
Name(s) of Medication: _____

Pet #2 Information

Name of Pet: _____
Canine Feline Other _____
Breed: _____ Male Female
Color: _____ Neutered Spayed
Date of Birth: _____ Age: _____ Is your pet micro chipped? Yes No
Do you have Pet Insurance for this pet? Yes No If yes, what type?_____
Is your pet currently taking medication: Yes No
Name(s) of Medication: _____

How did you hear about us?

Phone Book Internet/Website Human Society Newspaper Previous Client Saw Sign
Referral. Please print first and last name of person who referred you?_____
Other _____

Payment is expected at the time of service.

_____ (Initials) I hereby give Central Animal Hospital permission to share fun pictures of my pets on social media.