fishtown animal hospital
thefishtownanimalhospital.com

New Client Form

233 E. Girard Avenue
Philadelphia, PA 19125
Phone: 215.834.6993
Fax: 215.827.5929
info@fishtownvet.com

Owner's Information

First Name:	**Last Name:**	
Street Address:		
City:	**State:**	**Zip:**
Mobile Phone:	**Home Phone:**	
Email Address:		

Other Owner's Information*

First Name:	**Last Name:**
Mobile Phone:	**Home Phone:**
Email Address:	

**If the other owner resides at a different address, please provide that information at the front desk.*

Emergency Contact

In case of an emergency occurring during your pet's treatment and/or hospitalization at Fishtown Animal Hospital, during which we are unable to contact you and/or your partner based on the information you have provided us, would you like to designate another person for us to contact?

First Name:	**Last Name:**
Phone Number:	**Relationship to you:**

Permission to use photos: By selecting "Yes," I give my permission for images of my pet(s) and/or their veterinary care to be used by Fishtown Animal Hospital for education, promotion, and/or social media.

☐ No ☐ Yes

How did you become aware of our practice? ☐ Walked/Drove By ☐ Internet Search/Website ☐ Previous Client
☐ Personal Referral (Whom may we thank?):

☐ Other (please specify):

Please fill out the second page of this form

**Please use this page as many times as needed to include all of your pets. **

Pet's Information

Pet's Name:	**Sex:** ☐ Male, intact ☐ Female, intact ☐ Male, neutered ☐ Female, spayed	**Age or Birth Date:**
Species: ☐ Cat ☐ Dog ☐ Exotic/Pocket Pet (specify):	**Breed:**	**Color:**
Where Obtained:	**Age Obtained:**	
Where has your pet gone for veterinary care in the past?	**Is your pet's rabies vaccination up to date?** ☐ No ☐ Yes (date):	
Does your pet have any allergies? ☐ No ☐ Yes (specify):	**Has your pet ever had a reaction to a vaccine?** ☐ No ☐ Yes (specify):	
Is your pet currently on: ☐ Heartworm Preventative ☐ Flea and tick preventative ☐ Other medications (please list):		
Has your pet had any previous surgeries? ☐ No ☐ Yes (please list):		
Does your pet have a history of trauma, emergency, or other long-term hospitalization? ☐ No ☐ Yes (please list):		
For dogs only: **Do you have a current Philadelphia dog license? (If no, please speak with the front desk staff.)** ☐ No ☐ Yes: License Retailer: License Tag # : License Issued Date:		

Additional Pet's Information

Pet's Name:	**Sex:** ☐ Male, intact ☐ Female, intact ☐ Male, neutered ☐ Female, spayed	**Age or Birth Date:**
Species: ☐ Cat ☐ Dog ☐ Exotic/Pocket Pet (specify):	**Breed:**	**Color:**
Where Obtained:	**Age Obtained:**	
Where has your pet gone for veterinary care in the past?	**Is your pet's rabies vaccination up to date?** ☐ No ☐ Yes (date):	
Does your pet have any allergies? ☐ No ☐ Yes (specify):	**Has your pet ever had a reaction to a vaccine?** ☐ No ☐ Yes (specify):	
Is your pet currently on: ☐ Heartworm Preventative ☐ Flea and tick preventative ☐ Other medications (please list):		
Has your pet had any previous surgeries? ☐ No ☐ Yes (please list):		
Does your pet have a history of trauma, emergency, or other long-term hospitalization? ☐ No ☐ Yes (please list):		
For dogs only: **Do you have a current Philadelphia dog license? (If no, please speak with the front desk staff.)** ☐ No ☐ Yes: License Retailer: License Tag # : License Issued Date:		

By signing this form, I certify that I am 18 years of age or older, and that I am the person who is responsible for the welfare of the animal(s) ___________________________________, described on this form. I am responsible for communicating with the Fishtown Animal Hospital team concerning my pet(s)' diagnosis, treatment, and veterinary medical care. I understand that I have sole responsibility for all charges incurred in care of this animal. I understand that full payment in the form of cash, credit card, and/or care credit is due at the time of service, and that at the discretion of the hospital, a deposit may be required.

Printed Name: ____

Signed Name: ____ Date: _________________________

I understand that payment is due at time of service, and that payments are accepted in the forms of cash, all major credit cards, and CareCredit.

Printed name: ____

Signature: ____

Date: ____

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