



# Angel Fire Small Animal Hospital

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## New Client Information

Owner's Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Physical Address (if different than mailing address) : \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Spouse's Cell # \_\_\_\_\_

Work Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Driver's License # \_\_\_\_\_ Issuing State: \_\_\_\_\_

In case of EMERGENCY, call: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our clinic: \_\_\_\_\_  
(personal referral, another veterinarian, sign, ad in paper, website, or other)

## Pet's Information

Pet's Name: \_\_\_\_\_ Age \_\_\_\_\_ and/or Date of Birth \_\_\_ / \_\_\_ / \_\_\_

Species: \_\_\_ Canine \_\_\_ Feline Other \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Sex: \_\_\_ Male \_\_\_ Female has your pet been: \_\_\_ Neutered (male) \_\_\_ Spayed (female)

When was your pet last vaccinated? \_\_\_\_\_ Where: \_\_\_\_\_

In regards to your pet's behavior, are any of the following a concern to you?

- |                                       |   |                                       |  |
|---------------------------------------|---|---------------------------------------|--|
| <input type="checkbox"/> Shedding     | <input type="checkbox"/> Excessive Barking  | <input type="checkbox"/> Biting       | <input type="checkbox"/> Housebreaking |
| <input type="checkbox"/> Itching      | <input type="checkbox"/> Straying from home | <input type="checkbox"/> Strange Odor | <input type="checkbox"/> Misbehaving   |
| <input type="checkbox"/> Ear problems | <input type="checkbox"/> Coughing           | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Scooting      |

Other: (specify) \_\_\_\_\_

Has your pet ever had an allergic reaction to vaccines or any other medicine? If yes, explain: \_\_\_\_\_

Any other Past Medical Problems? Please describe below.....

If your pet ever becomes lost, do we have permission to release your contact information so that we may help reunite your pet? No \_\_\_\_\_ Yes \_\_\_\_\_ Address \_\_\_\_\_ Phone numbers \_\_\_\_\_

\*\*\*I understand that all fees are due at the time services are rendered and agree to these terms\*\*\*

Signature

Date