



**Weiser Veterinary Clinic**  
**815 W. Idaho St.,**  
**Weiser, ID 83672**  
**Ph: 208-549-0944 Fax: 208-549-2254**

Frank Coleman, DVM  
 Dennis Johnson, DVM  
 Jennie Walker, DVM  
 Tanya Percifield, DVM

## New Client Form

Thank you for giving us the opportunity to care for your pet(s). We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely. If you have health and/or vaccination records from a previous facility, please bring them with you so that we can copy them for your pet's health history. Again, thank you for choosing us!

(Please print) Date: \_\_\_\_\_  
**Owner Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ **Zip:** \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
 Spouse Name: \_\_\_\_\_ **SS#:** \_\_\_\_\_  
 Spouse Work Phone: \_\_\_\_\_ **Spouse Cell Phone:** \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ **Phone:** \_\_\_\_\_  
 How did you learn of our clinic?  Yellow Pages  Recommendation  Facebook  
 Internet Search  WVC Website  Sign  Other \_\_\_\_\_  
 If recommended, by whom? \_\_\_\_\_  
 Number of pets: Dogs: \_\_\_\_\_ Cats: \_\_\_\_\_ Horses: \_\_\_\_\_ Other: (specify) \_\_\_\_\_  
 Reason for visit: \_\_\_\_\_

<b>Pet's Name:</b> _____	<b>Species:</b> _____	<b>Breed:</b> _____
<b>Color:</b> _____	<b>Date of Birth:</b> _____	
<input type="checkbox"/> Male	<input type="checkbox"/> Neutered/Castrated	<input type="checkbox"/> Female <input type="checkbox"/> Spayed
<b><u>Vaccination History (Date and type of last vaccinations):</u></b> _____ _____		

**Please check (☒) any symptoms or problems that you have noticed about your pet.**

<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Eye Bulging or bloodshot	<input type="checkbox"/> Scratching	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Gagging	<input type="checkbox"/> Seems Depressed	<input type="checkbox"/> Weakness
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Lack of Appetite	<input type="checkbox"/> Shaking Head	
<input type="checkbox"/> Coughing	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Sneezing	
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Scooting	<input type="checkbox"/> Thirst and/or Urination Increased	
<input type="checkbox"/> Other: _____			

Pet's current medications: \_\_\_\_\_  
 Describe your pet's diet: \_\_\_\_\_

### AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Method of payment:  Cash  Check (5% discount if paying by cash or check at check-out)  
 MasterCard  Visa Other: \_\_\_\_\_