Arch Animal Hospital
2951 Dougherty Ferry
St. Louis, MO 63122
636-225-8387

NEW CLIENT FORM

Date: ____________________

Last Name: ____

First Name: ____

Address: ____

County: ____

Primary Phone: ____

Email Address: ____

Spouse/Secondary Contact: ____

Secondary Phone: ____

Previous veterinary hospital: ____

Pet #1

Name: ____ Canine Feline

Breed: ____ Color: ________________________

Date of Birth or Approximate Age: ___________________________ Sex: Male Female Neuter Spay

Pet #2

Name: ____ Canine Feline

Breed: ____ Color: ________________________

Date of Birth or Approximate Age: ___________________________ Sex: Male Female Neuter Spay

Do you give Arch Animal Hospital permission to release medical records to other veterinary facilities, groomer, or boarding facilities if requested? Yes _____No ____

I grant Arch Animal Hospital, its representatives, and employees the right to take photographs of me and/or my pet, and to copyright, use and publish the same in print and/or electronically. I agree that Arch Animal Hospital West may use such photographs of me and/or my pet with or without my name and for any lawful purpose, including, for example, such purposes as publicity, illustration, advertising, and Web content.

Yes ____No_____

I give Arch Animal Hospital permission to use my account information to issue a free Pet ID Card through our Practice Management Software annually and have it mailed to my address on file. Yes _____No ____

I understand that fees are payable at the time of services rendered.

Signature-____