



Guilford Veterinary Hospital, LLP

81 Saw Mill Road

Guilford, CT 06437

Phone: 203-453-2707 Fax: 203-453-2709

Please visit our website www.guilfordvet.com

NEW CLIENT INFORMATION

Owner: _____ Spouse/Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Spouse Work Phone: _____ Spouse Cell Phone: _____

How did you hear about us (please circle)? Phone Book Sign Advertisement Friend/Family Other
If Friend/Family, Name? _____

Animal #1

Name _____ Species _____ Breed _____ Sex M / F

Altered? Y / N Color/Description _____ Date of Birth/ Age _____

Taking any Medications? Y/N If yes, what: _____

Any known allergies? _____

What brand of food are you feeding? _____ Circle: Canned Dry

Animal #2

Name _____ Species _____ Breed _____ Sex M / F

Altered? Y / N Color/Description _____ Date of Birth/ Age _____

Taking any Medications? Y/N If yes, what: _____

Any known allergies? _____

What brand of food are you feeding? _____ Circle: Canned Dry

Animal #3

Name _____ Species _____ Breed _____ Sex M / F

Altered? Y / N Color/Description _____ Date of Birth/ Age _____

Taking any Medications? Y/N If yes, what: _____

Any known allergies? _____

What brand of food are you feeding? _____ Circle: Canned Dry

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

We will gladly prepare a written estimate if you desire. Please ask the doctor or receptionist.

I, the undersigned owner of the pet(s) identified above, consent to the examination of my pet(s) by Guilford Veterinary Hospital staff and after consultation with me to prescribe medication for, treat, hospitalize, anesthetize or perform surgery on my pet(s). I understand that some risks always exist with anesthesia and or surgery and that I am encouraged to discuss any concerns I have about those risks with my attending veterinarian before the procedure is initiated. Should some unexpected life-saving emergency care be required for my pet(s), Guilford Veterinary Hospital staff has my permission to provide such treatment and I agree to pay for such care.

Signature of Owner or Agent _____ Date: _____

(Must be 18 years of age or older)