

CLIENT INFORMATION



DATE: _____

PRIMARY OWNER: _____

SECOND OWNER(S): _____

ADDRESS: _____ APT.#: _____

CITY: _____ POSTAL CODE: _____

HOME PHONE: _____ BUSINESS PHONE: _____ MOBILE: _____

EMAIL ADDRESS: _____

- Yes, I confirm my consent to receiving email communications regarding my pets.
 Yes, I would like to register to receive East York Animal Clinic's newsletter, "Frodo's Thoughts".

PET INFORMATION

Name	Birth date/ Approx. age	Male or Female	Neutered or Spayed	Breed	Colour	Does your pet go outdoors?	Microchip/ Tattoo#

PLEASE LIST ALL VETERINARY CLINICS YOU HAVE PREVIOUSLY BROUGHT YOUR PET(S) TO:

**East York Animal Clinic veterinarians reserve the right to refuse to see any pet(s) whose full medical history is not disclosed.*

How did you become aware of our clinic? (Please check one only)

- Animal Wellness Magazine
 Yellow Pages
 Holistic Health & Wellness Directory
 Internet
 Sign at the front of our clinic
 Saw Dr. McCutcheon/Dr. Kneebone/Dr. Chiu on TV
 Was a previous client
 Referral; please specify by whom: _____

PLEASE NOTE THAT PAYMENT IS DUE AT THE TIME SERVICES ARE PERFORMED. WE DO NOT BILL.
WE ACCEPT CASH, VISA, MASTERCARD AND INTERAC. WE DO NOT ACCEPT CHEQUES.