



CLIENT INFORMATION

DATE: _____

PRIMARY OWNER: _____

SECOND OWNER(S): _____

ADDRESS: _____ APT #: _____

CITY: _____ POSTAL CODE: _____

HOME PHONE: _____ MOBILE: _____ WORK: _____

If you would like to receive email communications regarding your pets (such as reminders), please provide your

EMAIL ADDRESS: _____

Yes, I would like to register to receive East York Animal Clinic's newsletter, "Frodo's Thoughts".

PET INFORMATION

Name	Birth date/ Approx. age	Sex	Neutered or Spayed	Breed	Colour	Microchip/Tattoo#
		M F	Y N			
		M F	Y N			
		M F	Y N			

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.