SOUTH SHORE VETERINARY HOSPITAL

NEW CLIENT/NEW PATIENT INFORMATION:

Name: _____

Address: _____

City/Zip:_____

E-mail address (for sending reminders):

_____

Please check off primary # in box:

Home phone: _____ ☐

Work phone: _____ ☐

Cell phone: _____ ☐

Date: _____

CO-OWNER/SIGNIFICANT OTHER INFORMATION:

Name: _____

Address: _____

City/Zip:_____

Home phone: _____

Work phone: _____

Cell phone: _____

Date: _____

CO-OWNER/SIGNIFICANT OTHER INFORMATION:

Name: _____

Address: _____

City/Zip:_____

Home phone: _____

Work phone: _____

Cell phone: _____

Date: _____

CO-OWNER/SIGNIFICANT OTHER INFORMATION:

Name: _____

Address: _____

City/Zip:_____

Home phone: _____

Work phone: _____

Cell phone: _____

Date: _____

PET(S) INFORMATION:

Pet #1: _____ Male/Female Spayed/Neutered Canine/Feline

D.O.B. _____ Breed: _____ Color: _____

Pet #2: _____ Male/Female Spayed/Neutered Canine/Feline

D.O.B. _____ Breed: _____ Color: _____

Pet #3: _____ Male/Female Spayed/Neutered Canine/Feline

D.O.B. _____ Breed: _____ Color: _____

South Shore Veterinary Hospital charges $60 for any no-show appointment. We require 24hrs. advance notice of cancellations.

PICTURE WAIVER: I consent _____ / do not consent _____ to allow South Shore Veterinary Hospital to use pictures of my pet(s) on their website(s). Pictures are permanent property of South Shore Veterinary Hospital. It is understood that there will be no compensation at any time for pictures.

Signature: _____ Date: _____

6992 ROUTE 31 CICERO, NY 13039 ~ DR. HAMMERSCHMIDT ~ DR. FERGUSON ~ DR. KRETOW ~ DR. ANDERSON ~ DR.SPILLETT

Ph# 315-698-0190 ~ Fax # 315-698-0191 ~ www.vetcicero.com