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E-Mail: Info@HRAnimalHospital.com

New Client Form

YOUR INFORMATION

Last Name _____ First Name _____
Spouse Last Name _____ First Name _____
Address _____ Apt _____ Lot _____ Unit _____
City, State, ZIP _____
Home Phone () _____ Work Phone () _____
Cell Phone () _____ E-mail address _____
Spouse's Phone () _____
Date of Birth _____
Emergency Contact _____ Contact Number () _____
How would you prefer we contact you? Phone Call (Home Cell Work) Email
How did you hear about us? _____

YOUR PET'S INFORMATION

Name _____ Canine Feline Other _____ Age/DOB _____
Breed _____ Color _____ Gender: Male Neutered Female Spayed
Known Allergies? _____ Microchip No. (if applicable) _____
Medical Alert _____

Name _____ Canine Feline Other _____ Age/DOB _____
Breed _____ Color _____ Gender: Male Neutered Female Spayed
Known Allergies? _____ Microchip No. (if applicable) _____
Medical Alert _____

Name _____ Canine Feline Other _____ Age/DOB _____
Breed _____ Color _____ Gender: Male Neutered Female Spayed
Known Allergies? _____ Microchip No. (if applicable) _____
Medical Alert _____

Name of Previous Animal Hospital _____
Phone Number _____

****We will contact your previous veterinarian for you to obtain your pet's health history****