Lakeshore Animal Hospital
New Client/Patient Form

Thank you for trusting Lakeshore Animal Hospital to care for your pet. So that we may become better acquainted, please complete the following:

Client Information:

Owner 1: _____
Last First Middle Initial

Driver's License: _____ Social Security #: _____

Owner 2: _____ Relationship: _____
Last First Middle Initial

Current Address: _____
Street City State Zip

Primary Phone: _____ Secondary Phone: _____ Owner 2 Phone: _____

Email: _____ Preferred Communication: Email / Mail / Phone / SMS

Permission to use pictures, history, or medical information about your patients in the media?
i.e. Print materials, our website, or our facebook _____ Yes _____ No

Previous Vet: _____ Phone: _____

How did you hear about us?: _____

Patient Information:

Pet #1 (check one): _____ Cat _____ Dog

Name: _____

Breed: _____

Color: _____

Date of Birth: _____

Sex: _____

Spayed/Neutered: _____ Microchipped: _____

Known Medical Conditions: _____

Pet #2 (check one): _____ Cat _____ Dog

Name: _____

Breed: _____

Color: _____

Date of Birth: _____

Sex: _____

Spayed/Neutered: _____ Microchipped: _____

Known Medical Conditions: _____

Payment Policy: FULL PAYMENT IS EXPECTED UPON RENDERING OF SERVICES. Alternative payment plans must be discussed prior to the start of treatment. Deposits are required on major/surgical cases, trauma cases, and emergency work where hospitalization is required. There is a fee for all refunded checks. Outstanding balances upon accounts may result in account information being sent to a

_____ April 18, 2025

Signature of Owner or Agent: Date