



**CORNERSTONE  
VETERINARY CLINIC**

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**NEW CLIENT INFORMATION SHEET**

**Do you have pet health insurance for your pet?** YES NO

If yes, what company? \_\_\_\_\_

**Please fill-in the following information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Street: \_\_\_\_\_

City, ST: \_\_\_\_\_ Zip-code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

Preferred method of communication: Home Phone Cell Phone Work Phone email

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

How did you select our hospital? (Yellow pages, Personal Referral, Newspaper Ad, Sign, etc):

\_\_\_\_\_

If you were referred by one of our clients, please give us their name so we may thank them:

\_\_\_\_\_

**Payment is due at the time services are provided.** For your convenience we accept Cash, Check, Mastercard, Visa, American Express, and Care Credit.

**If planning to pay by Check, please enter the following:**

Driver's License #: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

We offer convenient phone and online prescription refills that can be delivered directly to your home. If you are interested, please let the receptionist know so we can enter your billing information.

## PET INFORMATION

### General Information:

Pet's Name: \_\_\_\_\_

Species: Circle One - DOG CAT OTHER \_\_\_\_\_

Sex: Circle One - Female Female Spayed Male Male Neutered

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Birth Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

### Medical History:

Previous Veterinarian: \_\_\_\_\_

May we contact your previous vet for your pet's complete medical records? YES NO

Date of Last Vaccinations:

Canine: DHLPP \_\_\_\_\_ Bordetella \_\_\_\_\_ Rabies \_\_\_\_\_

Feline: FVRCP \_\_\_\_\_ Leukemia \_\_\_\_\_ Rabies \_\_\_\_\_

Date of Last Heartworm Test: \_\_\_\_\_

Is your pet currently on a Heartworm and/or Flea Preventative? YES NO

If yes, please list what brand you currently use: \_\_\_\_\_

Please list any other pertinent medical history you think we should know about:

### Family Information:

Are there any children in this household? YES NO

Does anyone in this household have a compromised immune system? YES NO

Are there any other pets in this household? YES NO

If yes, what species and age? \_\_\_\_\_