

# Welcome

## Client Intake Form

### Client's Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_ E-mail: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ Phone: \_\_\_\_\_

### Secondary Contact Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

### Pet Information

Name: \_\_\_\_\_ Birthdate/Age: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Canine  Feline Breed: \_\_\_\_\_  
Microchip:  Yes  No Color: \_\_\_\_\_ Gender:  Male  Female  
# \_\_\_\_\_ Neutered / Spayed:  Yes  No

Does your pet have any existing medical conditions or on any medications?  
\_\_\_\_\_

### Other Pets

NAME	AGE	SPECIES	BREED	SEX	NEUTERED/SPAYED
		<input type="checkbox"/> Dog <input type="checkbox"/> Cat		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Dog <input type="checkbox"/> Cat		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Dog <input type="checkbox"/> Cat		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Authorization

I hereby authorize the veterinarian at MetroWest Veterinary Clinic to examine, prescribe, and/or treat the above-listed pet(s). I assume responsibility for all charges incurred in the care of these pets. I also understand that these charges will be paid at the time of release unless notated otherwise and that a deposit may be required for surgical treatment.

I grant MetroWest Veterinary Clinic permission to share and send any medical records pertaining to the above-mentioned pet(s) to, but not limited to, other Medical facilities or insurance companies

I grant MetroWest Veterinary Clinic's representatives and employees the right to take photographs of me and/or my pet(s) to be used for any lawful purpose, including, but not limited to, illustration, web content, or social media posts.

\_\_\_\_\_  
Owner/ Legal Representative

\_\_\_\_\_  
Date: