



STEVESTON VETERINARY HOSPITAL

Robert H. Galloway, D.V.M.
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7020 Francis Road, Suite 100
Richmond, BC V6Y 1A2
www.stevestonvethospital.com
(604) 274 - 9938

New Client Information Form

Last Name: _____

First Name(s): _____

Title: Ms. Mr. Mrs. Mr./Mrs. Dr.

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: () - Mobile: () -

Work Phone: () - Preferred: Home Mobile Work








Email: _____

* **Email Privacy Notice:** We will **never** use your email to send you spam marketing messages as your privacy is our utmost concern. We will **never** sell/distribute your email to third party companies.

If you wish to opt-in for examination or vaccination reminders, select this box:

**How did you
hear about us?**

- Friends/Family
- Veterinarian Referral*
*Name: _____

- Location
- Website
- Google/Bing/Yahoo
- Yelp/Foursquare
- Social Media:       

FOR OFFICE USE ONLY (NOTES):



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About Your Pet

Your Last Name: _____

Pet's Name: _____

Species: Canine Feline Rodent Rabbit Bird Other: _____

Breed: _____

Colour/Markings: _____

Sex: Male Neutered Male Female Spayed Female _____

Date of Birth: (dd/mm/yyyy) _____

Identification: Microchip Tattoo _____

Pet Temperament: No history of aggression May be aggressive – use caution _____

Medical conditions? Yes No Details: _____

Allergies? Yes No Details: _____

Any medications? Yes No Details: _____

Last vaccinations? Vaccine Type: _____ Date: _____

Vaccine Type: _____ Date: _____

Vaccine Type: _____ Date: _____

Vaccine Type: _____ Date: _____

Additional Details: _____

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