

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

Veterinary Hospital of New Waverly  
Steve VanWagner, DVM, MS Kim VanWagner, DVM  
455 Hwy 150, New Waverly, Texas 77358



Welcome, we are glad you are here!!

**New Client Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Salutation: Dr. Mr. Mrs. Miss  
Circle One

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Driver License # \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

**How did you first hear of Veterinary Hospital of New Waverly?**

Phone Book  Drove by Clinic  Personal Referral ( Who? ) \_\_\_\_\_

**Pet Information (Information for additional pets may be placed on back)**

1. Pet's Name: \_\_\_\_\_ Age: \_\_\_\_\_ (wks/mos/yrs) Birthdate: \_\_\_\_\_

Dog  Cat  Other \_\_\_\_\_ Sex  Male  Female  Neutered  Spayed Short/Med/Long hair  
Circle one

Breed: \_\_\_\_\_ Pet spayed/neutered at what age? \_\_\_\_\_ (wks/mos/yrs)

Color: \_\_\_\_\_ What age was pet obtained? \_\_\_\_\_ (wks/mos/yrs)

Pet was obtained from  Friend  Breeder  Pet Shop  Stray  Humane Society/Shelter  Other \_\_\_\_\_

Reason for obtaining pet (Check all that apply):  Companion  Protection  Breeding  Show  Other \_\_\_\_\_

Describe your pet's diet:  Dry food only  Canned food only  Dry/Canned food  
 Table Food ( Occasionally  Regularly  As a sole source of food)

Which brand of pet food do you feed? How much? Frequency?: \_\_\_\_\_

Reason for this visit today: \_\_\_\_\_

List your pet's current medications (Include dosage): \_\_\_\_\_

Please check any symptoms or problems you've noticed with your pet:

- Appetite Changes     Eye Problems     Scratching     Weakness     Coughing
- Behavioral Changes     Shaking Head     Gagging     Sneezing     Limping
- Breathing Problems     Gums Bleeding     Thirst     Depression     Diarrhea
- Vomiting     Scooting     Loss of Balance     Increased Urination

Other: \_\_\_\_\_

2. Vaccines: if animals are dropped off, we MUST have proof of current vaccines. Vaccines (Needed/last received):

I hereby authorize the veterinarian to examine, prescribe for or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that **ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. Acceptable Methods of Payment are: CASH, CHECK, ( CREDIT CARDS: AMEX, VISA, MASTERCARD), CARE CREDIT.**

Signature of client responsible for pet(s) \_\_\_\_\_

*PHOTO RELEASE FORM*

*I grant full permission to Veterinary Hospital of New Waverly to use any and all images taken of me or of my pets for the sole use of education, advertising, and promotion. This includes but is not limited to photographic prints and products, cds, dvds, Facebook page, Twitter, You Tube videos, and other social media sites, website blogs, and website display. I certify that I am eighteen (18) years of age or older. I understand that a parent or guardian must complete this form when granting a photo release involving a minor child(ren).*

\_\_\_\_\_  
*Signature of client*