



River Falls Veterinary Hospital
 1055 E. Cascade Avenue
 River Falls, WI 54022
 715-425-9550

NEW CLIENT/PATIENT INFORMATION

(Your) Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone Number (H) _____ (C) _____ (W) _____

E-Mail Address (opt) _____

Significant Other Name _____ Phone _____

1.) Pet Name _____ DOB _____ Breed _____

Color _____ Gender (circle) M / F Spayed/Neutered? Yes / No

2.) Pet Name _____ DOB _____ Breed _____

Color _____ Gender (circle) M / F Spayed/Neutered? Yes / No

Method of Payment (circle all that apply) Cash Check VISA MasterCard Discover

I understand payment is required at the time of service.

Signature _____

We look forward to helping you keep your pets healthy. If you have questions or comments please feel free to call us!

HOSPITAL POLICY

1. PAYMENT IS REQUIRED AT THE TIME OF SERVICE.
2. PLEASE CALL FOR AN APPOINTMENT AND NOTIFY US IN ADVANCE IF YOU NEED TO CANCEL OR RESCHEDULE.
3. ALL PETS MUST BE ON A LEASH OR KENNELED AT ALL TIMES.

THANK YOU! WE APPRECIATE YOUR PATRONAGE.