Calista Animal Hospital

1889 Calle De Ninos, Las Cruces, NM 88005
575-525-1000 Fax 575-523-7605

Today's Date: _____ Are you a new client or a previous client?

Client Name: Mr. Mrs. Ms. Dr. (circle one)

Name: _____ **Driver's License/SSN **** _____

** This information is for check processing/collecting only and is part of your private medical records. This information will not be used or disseminated for any other purpose.

Mailing Address _____ **City** _____ **ST** _____ **Zip** _____

Check here if mailing address is the same as physical

Physical Address _____ **City** _____ **ST** _____ **Zip** _____

Home Phone _____ **Cell** _____ **Email** _____

Owner's Employer _____ **Phone #** _____

If necessary, may we contact you at work? Yes no

Spouse/Co-owner _____ **Phone #** _____

Spouse/Co-owners Employer _____ **Phone #** _____

If necessary, may we contact you at work? Yes no

Emergency Contact _____ **Phone #** _____

Who may we thank for referring you to our hospital? _____

Privacy laws do not permit us to release medical information such as vaccine history without your permission. If another clinic, kennel or groomer requests this information may we release it? Please sign here to allow the release of this information:

_____ (option to sign)

(Continue to next page)

Pet Information
Please Provide Previous Records if Possible

Pet Name ___________________ Dog Cat Bird Other ____________

Breed ______________________ Color _________________ Birth Date _________________
(Approximate if necessary)

Sex: Spayed Female Female Neutered Male Male Microchip# ____________________

Is your pet: Allergic to vaccines or medications? ____
Currently taking medications/special diet? ____
Please list any previous illnesses/surgeries: ____

Pet Name ___________________ Dog Cat Bird Other ____________

Breed ______________________ Color _________________ Birth Date _________________
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