

Chatham Animal Hospital and Bird Clinic

New Patient Form

6719 Waters Avenue
Savannah, GA. 31406
Christopher H. Gall DVM
Phone (912) 352-0011 Fax (912) 352-2090

Date: ___/___/___ Client #: _____ Record #: _____ Microchip #: _____

****Please PRINT All Information Clearly****

Owners Name: _____ Spouse: _____

Address: _____ Apt./Lot #: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: () _____ - _____ Emergency Phone: () _____ - _____

E-Mail Address: _____ Who referred you to us? _____

Pets Name: _____ Date of birth: ___/___/___

Male _____ Female _____ Has your pet been spayed/neutered? Yes _____ No _____

Breed: _____ Colors(s): _____

Dog _____ Cat _____ Ferret _____ Bird _____ Snake _____ Other _____

Date of last vaccines: ___/___/___ Where? _____

Payment in full by cash, check, or credit card is expected when treatment is performed or animal is discharged. In case of emergency hospitalization, deposit arrangements must be made with the receptionist. If you are paying by check today, or any time in the future, or if your pet will be staying here for any reason, please complete the following:

Place of employment: _____

If military; list company, unit, and military I.D.

Work Phone: () _____ - _____ Drivers License #: _____

Signature of Owner or Responsible Party _____

