MOUNTAINSIDE ANIMAL HOSPITAL
& 24 Hour Emergency Services

New Patient Form

PLEASE PRINT CLEARLY 604 973 1247

Patient Information

Pet's Name:	Species: ☐Canine ☐Feline ☐Other
Breed:	Color:
Sex: ☐ Female Spayed ☐Female Intact ☐Male Neuteured ☐Male Intact	
Age or Birthday (mm/dd/yyyy):	
Insurance Provider and Policy Number:	
Regular Veterinary Clinic*:	
**By listing your regular veterinary clinic, you are authorizing all medical records of treatments performed at Mountainside Animal Hospital to be sent to the party above.*	

Client Information (Owner)

First Name:		Last Name:
E-mail*:		
**An e-mail is needed to send medical records & payment information; you will not receive any spam from MAH.*		
Address:		
Unit#:	City:	Postal Code:
Mobile:		Landline:

Secondary Contact

First Name:	Last Name:
Phone Number:	
**By listing the party above, you authorize them to make medical/financial decisions for the patient.*	

Do you give permission for us to share photos of your pet on social media?

☐Yes, you can tag me at: @_____ ☐No, please **do not take photos** of my pet

How did you hear about us? _____

Signature: _____ Date: _____

***PLEASE NOTE: Verbal harassment, abusive behaviour, foul language, physical assault, and threats will not be tolerated and may result in termination of services.**

PLEASE EMAIL THIS FORM TO: info@mountainside24er.ca