MOUNTAINSIDE ANIMAL HOSPITAL
& 24 Hour Emergency Services

New Patient Form

604 973 1247 info@mountainside24er.ca

PLEASE PRINT CLEARLY

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*:	
**You are authorizing all medical records of treatments performed at MAH to be sent to the party above as well as upon request from any veterinary clinic asking on your behalf.* ☐ *No, I do not consent to MAH sharing my pet's medical records with another Vet Clinic*	

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: _____

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

PLEASE, LEAVE THIS FORM BY THE FRONT DOOR.