

Client/Patient Information

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible please take the time to fill in this form completely. Thank You!!

Tell us about you!

Your name: _____ Spouse: _____

Address: (mailing if different) _____

City: _____ State: _____ Zip/Postal Code: _____

Home Phone: () _____ - _____ Business Phone: () _____ - _____

Cell Phone: () _____ - _____ Other Phone: () _____ - _____

Email: _____ (all reminders are sent via email-we do not share your information with anyone)

Who else is responsible or may be bringing your pet? *(only persons listed on this form will be permitted to bring your pet for an appointment, authorize, sign for or admit your pet for ANY services. Must be @ least 18yrs old.)*

Name: _____ Relationship: _____

Address: (mailing if different) _____

City: _____ State: _____ Zip/Postal Code: _____

Home Phone: () _____ - _____ Business Phone: () _____ - _____

Cell Phone: () _____ - _____ Other Phone: () _____ - _____

How did you hear about us?

Referred by the American Animal Hospital Association
Yellow Page Ad
Hospital Sign/Location
Other _____
Veterinary Practice
Individual/Friend

Name of person or veterinary practice that referred you to us: _____

Tell us about your pet!

Name: _____

Canine or Feline Breed: _____ Date of Birth: _____

Male or Female Spayed/Neutered/Unaltered Age when altered: _____

Color and Markings: _____

Microchip/Tattoo: _____

Pet Insurance Company: _____

Policy Number: _____ Agent's phone: _____

What is your pet's history?

Description/Date

Does your pet have any allergies to medications or other substances? _____

Describe your pet's diet: _____

Where does your pet live? Indoor? Outdoor? Both?

Are there any other pets in the household? _____

Does your pet suffer any of the following symptoms?

Behavior Problems	Lack of appetite	Sneezing	Thirst, Urination ↑
Bleeding Gums	Limping	Shaking Head	Vomiting
Breathing Problems	Loss of Balance	Scotting	Weakness
Coughing	Scratching	Depressed	Weight Problem
Diarrhea	Eye Bulging or Bloodshot		Gagging

When was the last time your pet was vaccinated/vaccine titers checked? _____

What vaccine/Titers has your pet had? _____

If Canine, when was your dog's last occult heartworm test? _____

Positive or Negative? If positive, was your pet treated? (how & when) _____

What type of heartworm preventative is your pet taking? _____

When was your pet's last Intestinal parasite test? _____ Positive or Negative?

If positive what type of parasite was detected? _____

If feline, what was the date of your cat's feline leukemia/aids test? _____

Positive or Negative? If positive, what if any treatment was advised? _____

Authorization

I hereby authorize the veterinarian and his/her agents to examine, prescribe for or treat the above described pet named _____, I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for extended treatment, surgical treatment and/or hospitalization.

Signature of owner or authorized agent of the

owner: _____ Date: _____

Preferred method of payment:

Cash Visa/MasterCard Debit Card Check

If writing a check please provide a driver's license # if your license is out of state we will also need your social security number:

NCDL: _____

State: _____ License #: _____

Social Security #: _____