

WELCOME

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 ensure the best care possible, please take the time to fill in this form completely. Thank you!

Client Information

Name _____ Date: _____
Last Name First Name Initial

Spouse/Partner: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Spouse/Partner- Work/Cell Phone: _____

E:Mail Address: _____ Driver's License # _____

Cell Phone: _____

Reason for visit: _____

How did you learn about our practice? _____

Pet Information

Pet's Name: _____ Type of Animal: ___ Canine ___ Feline ___ Other

Breed: _____

Sex: Male Neutered Female Spayed

Color: _____ Date of Birth: _____ Weight: _____

Microchip: _____

Has this pet been examined by a veterinarian within the past year: Y/N

Has this pet bitten anyone in the last ten days? Y/N

Please check any symptoms or problems that you have noticed about your pet:

- | | | |
|---|---|--|
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Limping | <input type="checkbox"/> Thirst and/or Urination increased |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Scooting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Weight Problem |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Seems Depressed | <input type="checkbox"/> Other |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Shaking Head | |

Current Medications, if any: _____

Describe your pet's Diet: _____

Prior Illness/Injury/Surgery: _____

Allergies to Medicine/Vaccines: _____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. 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 surgical treatment.

Signature of Owner/or acting as agent for the owner _____

Date: _____

Method of payment: Credit Card Check Cash Care Credit