WELCOME TO OUR CLINIC!

CLIENT 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 a moment to fill in this form completely. Thank you.

Date___________________

Owner Name(s) ____

Address ____

City ____________________________ State______________ Zip________________

Spouse/ Other ____

Email (optional) ____

Primary Phone _________________ Cell # ( )_______________ Work # ( )_____________

Emergency Contact ____

How did you learn about our hospital? ☐ Advertisement ☐ Recommendation ☐ Drive By/Sign ☐ Internet Search

Number of pets: Dogs ___________ Cats _____________ Other (specify)________________

PET HEALTH HISTORY

Name of Pet___________________________ ☐ Dog ☐ Cat ☐ Other:_____________________

Breed__________________________________ Color_____________ Age______________________

☐ Male ☐ Neutered ☐ Female ☐ Spayed

Vaccination History (Date & type of last vaccinations)________________________________

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Please check (√) any symptoms or problems that you have noticed about your pet.

☐ Appetite Change	☐ Lethargic	☐ Wound/Cut
☐ Behavior Problems	☐ Limping	☐ Other:
☐ Breathing Problems	☐ Loss of Balance	________________
☐ Diarrhea	☐ Scratching	________________
☐ Eye Problem	☐ Urination Problem	________________
☐ Ear Problem	☐ Vomiting/Gagging	________________

Pet's Current medications:____

____

Diet/Amount fed:____

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.

Signature of Owner_______________________________________ Date___________________