

WELCOME TO OUR PRACTICE

Client Information

Date: _____ Social Security #: _____
Name (Last Name, First): _____ Spouse _____
Address: _____
City/State/Zip: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____
Business Phone: (_____) _____ E-mail Address: _____
Emergency Contact Name: _____ Phone (_____) _____
How did you learn about our practice? _____
Number of pets (please specify by type): _____
Primary reason for visit: _____
Driver's License #: _____ State: _____ Date of Birth: _____

Pet Information

Pet's Name: _____ Dog Cat
Sex: M F Age: _____ Birth date: _____ Breed: _____
Color(s): _____ Neutered/Spayed: Yes No At what age? _____
What age was pet obtained? _____
From: Friend Breeder Pet Shop Shelter/Pound Other: _____
Reason for obtaining pet (check all that apply): Companion Protection
 Breeding Show Other: _____
Describe your pet's diet: _____
List your pet's current medication: _____
Is your pet on preventatives for: Heartworm: yes no Fleas/Ticks: yes no
Is your pet: Indoor Outdoor Is your pet microchipped: yes no, if yes # _____
Does your pet have allergies? What type? _____
Does your pet have health insurance? Yes No

Please check any symptoms or problems you've noticed with your pet:

<input type="checkbox"/> Appetite Loss	<input type="checkbox"/> Gagging	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Behavioral Changes	<input type="checkbox"/> Gums Bleeding	<input type="checkbox"/> Thirst
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Limping	<input type="checkbox"/> Urination Increase
<input type="checkbox"/> Coughing	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Depression	<input type="checkbox"/> Scooting	<input type="checkbox"/> Weakness
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Scratching	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Eye Disorders: _____	<input type="checkbox"/> Shaking Head	<input type="checkbox"/> Other: _____

Pet's History (check all that pet has received):

<input type="checkbox"/> Distemper/Parvo (Dog)	<input type="checkbox"/> Feline Leukemia/Aids Test	<input type="checkbox"/> Feline Leukemia
<input type="checkbox"/> Leptospirosis (Dog)	<input type="checkbox"/> FVRCP (Feline Distemper)	<input type="checkbox"/> FIP (Cat)
<input type="checkbox"/> Lyme (Dog)	<input type="checkbox"/> Rabies (Dog/Cat)	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Prior Illness (es): _____		
<input type="checkbox"/> Prior Surgery (ies): _____	<input type="checkbox"/> other: _____	

Authorization

I hereby authorize the veterinarian(s) to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED AND ARE PAYABLE BY CASH OR CREDIT CARD FOR THE FIRST TWO OFFICE VISITS.

Signature of client responsible for pet(s) _____ Date _____