WELCOME TO OUR CLINIC

We are glad to have the opportunity to care for your pet.
To ensure your pet gets the best care we can offer, please fill out this form completely.

Client Information:

Date:____/____/____

Owner's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Social Security No.___/___/___ Birthdate: ___/___/___

Home Phone: (__)_____ Work Phone: (__)_____

Employer:_____

Emergency Contact Name:_____ Phone: (__)_____

Number of Pets (please specify type):_____

Pet Health History:

Pets Name:_____ Age:_____

Type:_____ Breed:_____ Color:_____

Sex: M❑ F❑ Neutered/Spayed: Y❑ N❑ Date: ___/___/___

Current medications your pet is taking:_____

_____

Vaccination History:

❑ Distemper Date:___/___/___ ❑ Parvovirus Date:___/___/___ ❑ Rabies Date:___/___/___

Primary reason for visit:_____

Symptoms your pet is demonstrating:

❑ Appetite Loss	❑ Diarrhea	❑ Loss of Balance	❑ Thirst
❑ Behavioral Changes	❑ Eye Disorders	❑ Scooting	❑ Urination Increase
❑ Breathing Problems	❑ Gagging	❑ Scratching	❑ Vomiting
❑ Coughing	❑ Gums Bleeding	❑ Shaking Head	❑ Weakness
❑ Depression	❑ Limping	❑ Sneezing	❑ Other:_____

Prior Surgeries:_____

Prior Illnesses:_____

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 the animal. I also understand that all professional fees are due at the time services are rendered.

Signature of responsible party_____ Date:___/___/___

The information on this form is strictly confidential and is to be used only by this practice to provide care and treatment for your pet.