



Welcome to Our Practice



Client Information

Date: _____ Social Security Number: _____

Name: _____

Address: _____ City/State/ZIP: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Employer: _____

Emergency Contact: _____ Phone: (____) _____

How did you learn about our practice? _____

Primary reason for visit: _____

Pet Information

Pet's Name: _____ Dog Cat Other _____

Sex: M F Neutered/Spayed: Yes No At what age? _____

Age: _____ Birth date: _____ Breed: _____ Color: _____

What age was your pet obtained? _____

From: Friend Breeder Pet Stop Humane Society Other

Describe your pet's diet: _____

List your pet's current medications: _____



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 those pet has received and list date last given):

- | | |
|--|---|
| <input type="checkbox"/> Distemper _____ | <input type="checkbox"/> Feline Leukemia Test _____ |
| <input type="checkbox"/> Parvo virus (Dog) _____ | <input type="checkbox"/> FVRCP (Infectious Disease-Cat) _____ |
| <input type="checkbox"/> Rabies (Dog/Cat) _____ | <input type="checkbox"/> Dental _____ |
| <input type="checkbox"/> Prior Surgery: _____ | <input type="checkbox"/> Prior Illness: _____ |
| <input type="checkbox"/> Other: _____ | |

Prior Vet Clinic(s): _____ Address: _____

Phone: (____) _____

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 case of the animal. I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Signature of the client responsible for pet(s): _____

Date: _____

CONFIDENTIAL