



**WELCOME!** Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank you!

**Client Information**

Name(s): #1: \_\_\_\_\_ #2: \_\_\_\_\_  
 Cell Phone #1: (\_\_\_\_) \_\_\_\_\_ Cell Phone #2: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Home phone: (\_\_\_\_) \_\_\_\_\_ Employer: \_\_\_\_\_  
 Work phone: (\_\_\_\_) \_\_\_\_\_ Employer Address: \_\_\_\_\_  
 Non Owner Emergency Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 How did you learn about our practice?  Drive by  Yellow pages  Humane Society  
 Website  Referred By \_\_\_\_\_  
 Number of pets in household (please specify by type): \_\_\_\_\_  
 Primary reason for visit: \_\_\_\_\_  
 \*Email (please provide for your Pet Portals): \_\_\_\_\_

**Pet Information**

Pet's Name: \_\_\_\_\_  Dog  Cat  Other \_\_\_\_\_  
 Sex:  Male  Neutered  Female  Spayed Altered at what age? \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_  
 What age was pet obtained? \_\_\_\_\_  
 From:  Friend  Breeder  Pet Shop  Humane Society  Other: \_\_\_\_\_  
 Reason for obtaining pet (check all that apply):  Companion  Protection  Hunting  
 Breeding  Show  Other: \_\_\_\_\_  
 Describe your pet's diet:  Kibble  Canned Brand: \_\_\_\_\_  
 List your pet's current medication(s): \_\_\_\_\_

**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/bad breath | <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"/> Rash               |
| <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 (Dog/Ferret) | <input type="checkbox"/> Feline Leukemia Test           | <input type="checkbox"/> Prior Surgery: _____ |
| <input type="checkbox"/> Parvovirus (Dog)       | <input type="checkbox"/> FVRCP (Infectious Disease-Cat) | <input type="checkbox"/> Prior Illness: _____ |
| <input type="checkbox"/> Rabies (Dog/Cat)       | <input type="checkbox"/> Dental                         | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Allergies: _____       |   |   |

**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 inpatient treatment.*

Signature of Owner: \_\_\_\_\_ Date: \_\_\_\_\_

Method of Payment:  Cash  MasterCard (Credit/Debit)  Visa (Credit/Debit)  Care Credit  Check (with proper ID)

*\*Cash, Credit Card or Care Credit, are the preferred methods of payment\**