

## Welcome

Thank you for choosing us. Please take a few moments to fill out this form.

### Client Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ DL# \_\_\_\_\_

E-Mail \_\_\_\_\_ Would you like to receive e-mail reminders? \_\_\_\_\_

Spouse or Co-Owner's Name \_\_\_\_\_ E-Mail \_\_\_\_\_

Home Phone \_\_\_\_\_ CellPhone \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Relation \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

How did you learn about our practice? \_\_\_\_\_

### Pet Information

Pet's Name \_\_\_\_\_ Dog Cat Other \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex: Male Female Neutered/Spayed: Yes No

Breed \_\_\_\_\_ Color \_\_\_\_\_

Where did you obtain pet? Friend Breeder Pet Shop Shelter Other \_\_\_\_\_

Diet (kind of food) \_\_\_\_\_ Medication \_\_\_\_\_

Please describe any prior illness, surgery, or any allergies

\_\_\_\_\_

### Second Pet

Pet's Name \_\_\_\_\_ Dog Cat Other \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex: Male Female Neutered/Spayed: Yes No

Breed \_\_\_\_\_ Color \_\_\_\_\_

Where did you obtain pet? Friend Breeder Pet Shop Shelter Other \_\_\_\_\_

Diet (kind of food) \_\_\_\_\_ Medication \_\_\_\_\_

Please describe any prior illness, surgery, or any allergies

\_\_\_\_\_

### Payment

We will gladly prepare a written estimate of service fees if you desire (please ask receptionist). All professional fees are due at the time services are rendered. In case of extensive medical or surgical procedures where full payment may be difficult at discharge, we accept major credit cards (MasterCard, Visa, and Discover) or can establish a payment arrangement if approved in advance of treatment. There will be a service charge for any check returned unpaid.

To prevent the spread of infectious diseases, all hospitalized patients and boarders must be current on all vaccinations and free from internal and external parasites. The signature below authorizes this level of preventative care and the appropriate charges will be assessed in the discharge invoice.

Signature of client responsible for pet(s) \_\_\_\_\_ Date \_\_\_\_\_

## Additional Pets

Pet's Name \_\_\_\_\_ Dog      Cat      Other \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex: M/F \_\_\_\_ Neutered/Spayed: Y/N \_\_\_\_ Breed \_\_\_\_\_

Where did you obtain pet?    Friend      Breeder      Pet Shop    Shelter      Other \_\_\_\_\_

Diet (kind of food) \_\_\_\_\_ Medication \_\_\_\_\_

Please describe any prior illness, surgery, or any allergies

\_\_\_\_\_

\_\_\_\_\_

Pet's Name \_\_\_\_\_ Dog      Cat      Other \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex: M/F \_\_\_\_ Neutered/Spayed: Y/N \_\_\_\_ Breed \_\_\_\_\_

Where did you obtain pet?    Friend      Breeder      Pet Shop    Shelter      Other \_\_\_\_\_

Diet (kind of food) \_\_\_\_\_ Medication \_\_\_\_\_

Please describe any prior illness, surgery, or any allergies

\_\_\_\_\_

\_\_\_\_\_

Pet's Name \_\_\_\_\_ Dog      Cat      Other \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex: M/F \_\_\_\_ Neutered/Spayed: Y/N \_\_\_\_ Breed \_\_\_\_\_

Where did you obtain pet?    Friend      Breeder      Pet Shop    Shelter      Other \_\_\_\_\_

Diet (kind of food) \_\_\_\_\_ Medication \_\_\_\_\_

Please describe any prior illness, surgery, or any allergies

\_\_\_\_\_

\_\_\_\_\_

Pet's Name \_\_\_\_\_ Dog      Cat      Other \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex: M/F \_\_\_\_ Neutered/Spayed: Y/N \_\_\_\_ Breed \_\_\_\_\_

Where did you obtain pet?    Friend      Breeder      Pet Shop    Shelter      Other \_\_\_\_\_

Diet (kind of food) \_\_\_\_\_ Medication \_\_\_\_\_

Please describe any prior illness, surgery, or any allergies

\_\_\_\_\_

\_\_\_\_\_

Pet's Name \_\_\_\_\_ Dog      Cat      Other \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex: M/F \_\_\_\_ Neutered/Spayed: Y/N \_\_\_\_ Breed \_\_\_\_\_

Where did you obtain pet?    Friend      Breeder      Pet Shop    Shelter      Other \_\_\_\_\_

Diet (kind of food) \_\_\_\_\_ Medication \_\_\_\_\_

Please describe any prior illness, surgery, or any allergies

\_\_\_\_\_

\_\_\_\_\_