

CLIENT AND PATIENT INFORMATION

HOME PHONE NUMBER: _____

TITLE: MR / MRS / MISS / MS / MR & MRS / DR / DR & MRS / REV / REV & MRS (circle one)

NAME: _____

ADDRESS: _____
(last) (first)
(street) (city) (state) (zip)

Email address: _____ If you would like to receive periodic communications from us.

PLACE OF EMPLOYMENT: _____ WORK PHONE: _____

* If paying by check: DL Number _____ and Date of Birth _____

SPOUSE'S NAME: _____

SPOUSES'S EMPLOYER: _____ WORK PHONE: _____

IS THIS YOUR FIRST VISIT TO OUR HOSPITAL? YES NO

IF YES, HOW DID YOU BECOME AWARE OF US? INTERNET NEWSPAPER RETURN CLIENT

REFERRING HOSP SIGN OR LOCATION MAIL PET STORE YELLOW PAGES
 DOG WARDEN SPCA _____

PERSONAL REFERRAL-whom may we thank? Please include address:

1) PET'S NAME: _____ Is your pet a: DOG / OTHER / CAT (INDOOR ONLY?) YES NO

BREED: _____ COLOR: _____ BIRTH DATE: _____
MALE FEMALE SPAYED CASTRATED UNKNOWN (circle one)

2) PET'S NAME: _____ Is your pet a: DOG / OTHER / CAT (INDOOR ONLY?) YES NO

BREED: _____ COLOR: _____ BIRTH DATE: _____
MALE FEMALE SPAYED CASTRATED UNKNOWN (circle one)

3) PET'S NAME: _____ Is your pet a: DOG / OTHER / CAT (INDOOR ONLY?) YES NO

BREED: _____ COLOR: _____ BIRTH DATE: _____
MALE FEMALE SPAYED CASTRATED UNKNOWN (circle one)

PAYMENT POLICY

All fees and charges are due and payable when services are rendered, or upon release of your pet.

CIRCLE PREFERRED METHOD OF PAYMENT: VISA MASTERCARD DISCOVER CASH CHECK*

Balances not paid will be sent to a reputable collection agency. Client signed below is responsible for all collection fees (33-40%) and any attorney fees.

Sign here: _____

WOULD YOU LIKE TO DISCUSS FEES BEFORE WE BEGIN OUR TREATMENT/DIAGNOSTIC PLAN? YES / NO

MEDICAL HISTORY

HAS YOUR PET BEEN TO A VETERINARIAN BEFORE? _____

PREVIOUS VETERINARIAN? _____

IF SO, IS THERE A REASON FOR CHANGING?

DATE OF LAST VISIT _____ **DATE OF LAST VACCINATION** _____

ARE YOU INTERESTED IN LEARNING ABOUT PREVENTATIVE PROGRAMS TO PROTECT YOUR PET FROM INTERNAL PARASITES?

ARE YOU AWARE OF THE HEALTH BENEFITS OF REGULAR PET DENTAL CLEANING?

ARE YOU INTERESTED IN LEARNING ABOUT PRECISELY FORMULATED DIETS THAT HELP PREVENT DISEASE AND INCREASE YOUR PET'S HEALTH FOR A HAPPY LONG LIFE?

WHAT DO YOU CURRENTLY FEED YOUR PET? _____

DO YOU HAVE OTHER PET'S AT HOME? _____

HAS YOUR CAT BEEN TESTED FOR FELINE LEUKEMIA AND AIDS? _____

HAVE YOU NOTICED ANY BEHAVIOR PROBLEMS OR CONCERNS WITH YOUR PET?

DO YOU HAVE ANY CONCERNS ABOUT YOUR PET'S HEALTH THAT YOU DESIRE ADVICE ON FROM US?

WHAT PRIOR ILLNESS, SURGERY OR ALLERGIES SHOULD WE KNOW ABOUT?

WHAT TYPE OF FLEA CONTROL ARE YOU USING? _____

LIST ANY MEDICATIONS OR PRESCRIPTION DIET THAT YOUR PET IS ON. _____

ARE THERE TIMES YOU ARE IN NEED OF BOARDING AND/OR GROOMING SERVICES FROM US?

THANK YOU FOR BRINGING YOUR PET TO OUR HOSPITAL. WE HOPE YOU ARE PLEASED WITH OUR SERVICES AND WOULD APPRECIATE YOU SHARING WITH US ANY IDEAS YOU MAY HAVE AS TO HOW WE MAY IMPROVE THEM.