CLIENT AND PATIENT INFORMATION

HOME PHONE NUMBER: _____

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

NAME: _____
(last) (first)

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

PLACE OF EMPLOYMENT: _____ WORK PHONE: _____

DRIVER'S LICENSE NUMBER: _____ DATE OF BIRTH: _____

SPOUSE'S NAME: _____

SPOUSES' 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 _____

_____

E-MAIL ADDRESS: _____

HOW WOULD YOU LIKE TO RECEIVE YOUR REMINDERS? MAIL ❑ E-MAIL ❑

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 AN ESTIMATE BEFORE WE BEGIN TREATMENT YES / NO

TURN PAGE AND COMPLETE THE MEDICAL HISTORY ON THE REVERSE SIDE

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 CLEANINGS? _____

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 PETS 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.