

Thank you for allowing us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To ensure the best care possible, please take a few moments to print and bring in the completed form to the office with you.

Name: Last _____ First _____ Int. _____ Title _____

Address _____ City _____ State: _____ Zip _____

Phone: Home _____ Work _____ Cell/Pager _____

SS# _____ License#/State _____

Employer: _____ Employer Address _____

Pet Information

Patient Name: _____ Birth Date: ___/___/___ Species: Dog Cat

Male Neutered: Yes No Female Spayed: Yes No

Breed: _____ Color: _____

Vaccination History: Name & Phone # of Previous Clinic: _____ Date and Type of Vaccinations: _____

Please Check any of the symptoms or problems you have noticed in your pet:

Coughing <input type="checkbox"/>	Limping <input type="checkbox"/>	Scotting <input type="checkbox"/>	Shaking Head <input type="checkbox"/>
Scratching/Chewing <input type="checkbox"/>	Lethargic <input type="checkbox"/>	Depressed <input type="checkbox"/>	Weight Loss <input type="checkbox"/>
Loss of Balance <input type="checkbox"/>	Behavior Problems <input type="checkbox"/>	Eating more/less than normal <input type="checkbox"/>	Weight Gain <input type="checkbox"/>
Sneezing <input type="checkbox"/>	Vomiting <input type="checkbox"/>	Drinking more/less than normal <input type="checkbox"/>	
Diarrhea <input type="checkbox"/>	Gagging <input type="checkbox"/>	Hair Loss <input type="checkbox"/>	

Other not listed: _____

Pet's Current Medication: _____

Describe Pet's Diet: Dry: _____ Canned: _____ Moist: _____
Frequency: _____

Authorization

FULL PAYMENT IS DUE AT TIME OF SERVICE

I hereby authorize the veterinarian to examine, prescribe for or treat the above described pet. I assume responsibility for all charges incurred in the treatment of this animal. I am aware that a deposit may be required for treatment.

Payment Method : CASH CHECK VISA MASTERCARD OTHER _____

Signature: _____ Date: _____