Welcome to our clinic

Client Information

Date____/_____/____

Pet Owner Information:

First/Last Name:_____
Address:_____ZIP_____
Home Phone:(___)_____Cell Phone:(___)_____DL#_____
Employer_____Wrk#_____EXT_____
Emergency Contact:_____Phone#_____
Email:_____optional

PET Health History

Pets Name:_____Age:_____DOB___/__/___
Canine / Feline Breed:_____Color_____
Sex:_____Spayed?Y__N__/Neutered? Y__N__Microchip:_____
Vaccination History:_____Rabies Vaccination Date:_____
Current Medication_____
Primary Reason For Visit:_____

Symptoms your pet is Demostrating:

()Appetite Loss ()Diarrhea ()Loss of Balance ()Thirst ()Behavioral Changes
()Eye Disorders ()Scooting ()Breathing Problems()Increase Urination
()Vomiting ()Scratching()Gagging ()Coughing ()Depression
()Bleeding Gums ()Limping ()Shaking Head ()Weakness ()Sneezing
()Other_____anything else we should know about your pet_____
_____

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 my pet. I also understand that **ALL FEES ARE DUE AT THE TIME OF SERVICES ARE RENDERD IN THE FORM OF: Cash, Debit/Credit, and Check (Whit Proper Identification)**

Signature of a Responsible Party:_____Date___/___/___

YOU MUST BE OVER THE AGE OF 18 YEARS TO SIGN