Animal Care Hospital

New Client/Pet Form

Date: _____

Owner's First Name: _____ **Owner's Last Name:** _____

Primary Phone _____ **Secondary Phone** _____

Spouse or Co-Owner Name: _____ **Home Phone** _____

Work Phone _____ **Emergency Phone** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Email Address: _____ **Employer:** _____

How did you hear about us? _____

Referred by (We would like to thank them): _____

NAME AND NUMBER OF PREVIOUS VETERINARIAN:

_____

Are there other pets in your household? YES / NO

If yes, please indicate quantity below:

Dogs: _____ Cats: _____ Birds: _____

Reptiles: _____ Rabbits: _____ Other: _____

PET INFORMATION MALE FEMALE

Pet's Name: _____

DOB/AGE: _____ **Species:** _____

Breed: _____ **Color:** _____

SPAYED/NEUTERED YES NO

How long have you had your pet? _____

Medical Conditions that we need to be aware of:
(allergies, drug reactions, heart conditions, etc.)

_____

_____

_____

What does your pet eat?

Dry Brand: _____

Canned Brand: _____

People Food: _____

Vaccination History *(indicate the date - dd/mm/yy - your pet last received the following vaccinations) - or - write NOT SURE*

CANINE DHP: _____ Parvovirus: _____

Bordetella: _____ Rabies: _____

Other: _____

FELINE Rabies: _____ FVRCP: _____

Leukemia: _____ Other: _____

DENTAL CARE

Do you brush your pet's teeth? YES NO

Date of last clinic dental cleaning? _____

Has your pet had any of the following in the past week?

_____ Vomiting ____ Diarrhea ____ Cough

_____ Sneezing ____ Appetite Change

_____ Weakness/Lethargy

_____ Depression/Attitude Change

CURRENT MEDICATIONS:

_____

What is your primary reason for your visit today?

_____

_____