Patient Information Form

Client Information

Please circle one: Mr., Mrs., Ms. Date _____

Owner's Name _____ Driver License # _____

Address _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Cell _____ Cell _____ Work _____

Spouse _____ Emergency Contact _____ Emergency Phone # _____

How did you hear about us? Phone book, Sign, Internet, Mailer, Recommendation, other? (Please circle one)

If recommended, by whom? _____

How many dogs do you have _____ cats _____ other (specify) _____

Reason for visit _____

Patient Information

Name of Pet _____ Dog ( ) Cat ( ) Other _____ Sex (M) (Neutered)

Breed _____ Color _____ Date of Birth _____ (F) (Spayed)

Please check any symptoms or problems that you have noticed about your pet:

( ) Behavior Problems	( ) Lack of Appetite	( ) Sneezing	( ) Bleeding Gums
( ) Limping	( ) Thirst or Urination Increase	( ) Breathing Problems	( ) Loss of Balance
( ) Vomiting	( ) Coughing	( ) Scooting	( ) Weakness
( ) Eye Bulge or Bloodshot	( ) Scratching	( ) Gagging	( ) Seems Depressed
( ) Shaking Head	( ) Diarrhea	( ) Other	

Pet's Current Medications _____

Pet's Diet _____

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 this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner _____ Date _____