



## Pet Information

please complete for each pet

Pet's Name: \_\_\_\_\_

Pet Species:  Canine  Feline  Bird  Small Mammal  
 Reptile  Amphibian  Other \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Sex:  Male  Female Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Does your pet have an I.D. Microchip:  Yes  No

Neutered/Spayed:  Yes  No If yes, at what age: \_\_\_\_\_

Temperament:  Outgoing/Social  Neutral  Shy  Aggressive

Did you bring your pet's medical records?  Yes  No

What vaccines has your pet received? Date received: \_\_\_\_\_

DOG:  DHPP  Rabies  Parvo  Bordetella  Lepto  Lyme

CAT:  FVRCP  Rabies  Leukemia  FIV

Last heartworm test date : \_\_\_\_\_ Fecal test date: \_\_\_\_\_

Is your pet on parasite prevention?  Yes *please specify*  No

Does your pet have allergies?  Yes *please specify*  No

Has your pet ever had a dental cleaning?  Yes  No

Please list any prior illness or surgery: \_\_\_\_\_

Taking any special diets or medications: \_\_\_\_\_

## ASSESSING YOUR PET'S HEALTH RISK

How many hours a day does your pet spend outdoors? \_\_\_\_\_

Is your pet allowed to run free or come in contact with other animals?  Yes  No

Board, professionally groom or show your pet?  Yes  No

Take your pet hunting, swimming, hiking in areas with increased exposure to ticks, wildlife or access to rivers or streams?  Yes  No

Do you travel with your pet?  Yes *please specify*  No

## TELL US WHAT CONCERNS YOU ABOUT YOUR PET?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bad Breath       | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> House soiling      |
| <input type="checkbox"/> Coughing         | <input type="checkbox"/> Barking             | <input type="checkbox"/> Behavior changes   |
| <input type="checkbox"/> Ear Problems     | <input type="checkbox"/> Itching/scratching  | <input type="checkbox"/> Sores/wounds       |
| <input type="checkbox"/> Not Eating       | <input type="checkbox"/> Clawing/digging     | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Lameness            | <input type="checkbox"/> Aggression         |
| <input type="checkbox"/> Vomiting         | <input type="checkbox"/> Problems getting up |   |
| <input type="checkbox"/> Other _____      |  |   |

## Client Services

Animal Family is pleased to offer a wide range of pet health and client services. Please tell us your areas of interest.

- |   |   |
|---|---|
| <input type="checkbox"/> Wellness Care/Vaccines | <input type="checkbox"/> Puppy Classes    |
| <input type="checkbox"/> Puppy/Kitten Packages  | <input type="checkbox"/> Boarding/DayCare |
| <input type="checkbox"/> Surgical Care          | <input type="checkbox"/> Grooming         |
| <input type="checkbox"/> Dental Care            | <input type="checkbox"/> Referral Program |
| <input type="checkbox"/> Nutrition              | <input type="checkbox"/> _____            |

## CLIENT AND PATIENT INFORMATION

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. We look forward to working with you in maintaining your pet's health.

### Client Information

#### Owner Contact Information

Name: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Best time to call: \_\_\_\_\_

Driver's License # \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Bus. Ph: \_\_\_\_\_

Notify in case of emergency : \_\_\_\_\_

Home Ph: \_\_\_\_\_ Other Ph: \_\_\_\_\_

Please tell us how you learned about us?  Pet Store  Humane Society  
 Saw your sign  Yellow Pages  Received a mailing  Penny Saver Ad  
 Flyer/Brochure  New Resident Program  Newspaper Ad  Internet

Referred by a friend – Who may we thank for this referral?

#### Spouse or Co-Owner Contact Information

Name: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Email Address: \_\_\_\_\_

#### FINANCIAL POLICY: ANIMAL FAMILY VETERINARY CARE CENTER

requires payment in full for professional services when your pet is discharged from the hospital. As legal owner or responsible agent of the above animal(s), I certify that I have read and agree to this financial policy. I hereby assume financial responsibility for all services rendered.

Choice of payment:  Cash/Check/Debit  VISA/MC/Disc  CareCredit

Signature owner/agent: \_\_\_\_\_

Date: \_\_\_\_\_

**Thank You!**

## Pet Information

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Pet Species:  Canine  Feline  Bird  Small Mammal  
 Reptile  Amphibian  Other \_\_\_\_\_  
Breed: \_\_\_\_\_ Color: \_\_\_\_\_  
Sex:  Male  Female Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Does your pet have an I.D. Microchip?  Yes  No  
Neutered/Spayed:  Yes  No If yes, at what age: \_\_\_\_\_  
Temperament:  Outgoing/Social  Neutral  Shy  Aggressive  
Did you bring your pet's medical records?  Yes  No  
What vaccines has your pet received? Date received: \_\_\_\_\_  
DOG:  DHPP  Rabies  Parvo  Bordetella  Lepto  Lyme  
CAT:  FVRCP  Rabies  Leukemia  FIV  
Last heartworm test date : \_\_\_\_\_ Fecal test date: \_\_\_\_\_  
Is your pet on parasite prevention?  Yes please specify  No  
Does your pet have allergies?  Yes please specify  No  
Has your pet ever had a dental cleaning?  Yes  No  
Please list any prior illness or surgery: \_\_\_\_\_  
\_\_\_\_\_  
Taking any special diets or medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Take your pet hunting, swimming, hiking in areas with increased exposure to ticks, wildlife or access to rivers or streams?  Yes  No  
Do you travel with your pet?  Yes please specify  No

### TELL US WHAT CONCERNS YOU ABOUT YOUR PET?

Bad Breath  Diarrhea  House soiling  
 Coughing  Barking  Behavior changes  
 Ear Problems  Itching/scratching  Sores/wounds  
 Not Eating  Clawing/digging  Separation anxiety  
 Weight gain/loss  Lameness  Aggression  
 Vomiting  Problems getting up  
 Other \_\_\_\_\_

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