

# Community Pet Health Center: New Client and Pet Information Form

Pet Owner's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse/Co-Owner's Name: \_\_\_\_\_ Spouse/Co-Owner Cell Phone: \_\_\_\_\_

Spouse/Co-Owner Employer: \_\_\_\_\_ Spouse/Co-Owner Work Phone \_\_\_\_\_

In order to have online access to manage your pet's health, we need your email address (please print clearly):

\_\_\_\_\_ We respect your privacy and will not share your email address with other parties.

**How did you hear about us?** Hospital Sign/Drive by \_\_\_\_\_ Web Site \_\_\_\_\_ AT&T Yellow Pages (Print) \_\_\_\_\_

AT&T Yellow Pages (Internet) \_\_\_\_\_ Yellow Book (Print) \_\_\_\_\_ Yellow Book (Online) \_\_\_\_\_

Other (Please Specify) \_\_\_\_\_ Referred by a Friend \_\_\_\_\_

## **Pet Information**

*(Please use additional pet form for each pet we are seeing)*

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

Birth Date or Approx Age \_\_\_\_\_

Species \_\_\_\_\_ Breed \_\_\_\_\_ Color \_\_\_\_\_

Female Spayed? **YES NO**

Male Neutered? **YES NO**

## **Medical Conditions**

(Allergies, drug reactions, heart conditions, overweight, etc.)

\_\_\_\_\_  
\_\_\_\_\_

## **Vaccination History**

(Indicate the date (month/year) your pet received the following vaccinations)

K9 Rabies \_\_\_\_\_ K9 Distemper/Parvo \_\_\_\_\_

Bordatella (Kennel Cough) \_\_\_\_\_ Rattlesnake \_\_\_\_\_

Other \_\_\_\_\_, Describe: \_\_\_\_\_

Heartworm Test \_\_\_\_\_

Feline Rabies \_\_\_\_\_ Feline Distemper \_\_\_\_\_

Feline Leukemia \_\_\_\_\_ Feline FIV \_\_\_\_\_

Other \_\_\_\_\_, Describe: \_\_\_\_\_

## **Nutrition**

Dry Brand \_\_\_\_\_

Canned Brand \_\_\_\_\_

Table Scraps? **YES NO**

## **Dental Care**

Do you brush your pet's teeth? **YES NO**

Date of last professional dental cleaning? \_\_\_\_\_

## **Heartworm Preventative**

Is your pet currently taking heartworm preventative?

**YES NO** If yes, Brand \_\_\_\_\_

**Microchip Identification #** \_\_\_\_\_

## **Medical Records**

\_\_\_\_\_  
Name of hospital where they can be obtained

**I UNDERSTAND THAT PAYMENT IS DUE IN FULL AT TIME OF SERVICE. (A deposit is required on all pets admitted to the hospital.)**

**Signature:** \_\_\_\_\_

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

**How do you plan to pay?** \_\_\_ Cash \_\_\_ Check\*  
\_\_\_ Credit/Debit Card

**\*THE FOLLOWING INFORMATION MUST BE PROVIDED IF YOU INTEND TO PAY BY CHECK. WITHOUT THIS INFORMATION, ONLY CASH OR CREDIT CARD TRANSACTIONS CAN BE ACCEPTED. All information provided will be kept in strictest confidence and not released without your permission.**

Driver's Lic: State \_\_\_\_\_ # \_\_\_\_\_

Soc Sec #: \_\_\_\_\_ DOB: \_\_\_\_\_