Date:____ /_____ /_____

Owner's Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: ____ /___ /___ Phone: (__) _____ Email: _____

SS#_____

DL#_____

Spouse's name:_____

Spouse's employer:_____Work Phone: (__) _____

Employer:_____ Work Phone: (__) _____

Emergency Contact Name: _____ Phone: (__) _____

Number of Pets (please specify type): _____

Pet Health History:

Pet's Name:_____ Age:_____

Type:_____ Breed:_____ Color:_____

Sex: M ❑ F ❑ Neutered/Spayed: Y ❑ N ❑ Date: ___ /____ /____

Current medications your pet is taking:_____

_____

Vaccination History:

❑ Distemper Date:___ /___ /___ ❑ Parvovirus Date:___ /___ /___ ❑ Rabies Date:___ /___ /___

Primary reason for visit:_____

Prior Surgeries:_____

Prior Illnesses: _____

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 the animal. I also understand that all professional fees are due at the time services are rendered.

Signature of responsible party_____ Date:___ /___ /___

The information on this form is strictly confidential and is to be used only by this practice to provide care and treatment for your pet.