

WELCOME

CLIENT INFORMATION:

Name (and Spouse): _____

Drivers License#: _____ Birthdate: _____ Spouse's Birthdate: _____

SSN: _____ Spouse's SSN: _____

Address: _____ City/State/Zip: _____

Email Address: _____ Spouse's Email Address: _____

Home Phone: () _____ Cell: () _____ Spouse Cell: () _____

Employer and Address: _____

Employer's Phone #: () _____ Spouse Employer's #: () _____

Spouse's Employer and Address: _____

How did you learn about us? Internet Sign/Location Coupon/Flyer Phone Book

Pet Store (Which one): _____ Church Bulletin (which one): _____

Current Client/Friend (Who): _____

PET INFORMATION: Is your pet microchipped? YES/NO Microchip #: _____

Pet's Name: _____ Circle one: Dog / Cat Age or Birthdate: _____

Sex: Male / Female **Is your pet:** Spayed/Neutered @ what age? _____ What age was pet obtained? _____

Breed: _____ Color/Markings: _____

How did you obtain pet? Friend / Breeder / Pet Shop/Humane Society/Shelter (Which one): _____

What do you feed your pet (List all): _____

Is your pet on any medication? (If yes please list): _____

Is pet on Heartworm Prevention? Flea Prevention? What kind? _____

Where was the preventative(s) purchased? _____

AUTHORIZATION:

I certify that I am the owner of this animal and I am 18 years old or older. I hereby authorize the veterinarian to examine, prescribe for, and treat the animal described above. I understand that I am responsible for all charges incurred for the care of this animal. I understand that **ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED** and **ALL SALES ARE FINAL – NO REFUNDS WILL BE GIVEN.** I also understand that all records, lab work, and radiographs are sole property of SRVH and will be used at our discretion only. If SRVH cannot obtain payment for any reason I understand that I will be responsible for all fees, late payment, services charges, collection charges, court cost, attorney fees, and any other fees that may be incurred while trying to obtain payment.

Please indicate method of payment:

Cash, ***Check**, **Visa/MasterCard/Discover/Amex, Debit, and Care Credit.

**All checks include current, physical address, home phone number, valid driver's license number, phone number and date of birth. There is a \$50.00 NSF fee. ** Administrative fees can apply.*

Signature of person responsible for pet: _____ **Date:** _____

Client Name: _____ Pet Name: _____ Date: _____

PLEASE CHECK ALL SYMPTOMS/PROBLEMS YOU'VE NOTICED WITH YOUR PET OR THAT YOUR PET HAS BEEN TREATED FOR:

- | | | | |
|--|---|---|-------------------------------------|
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Behavioral Changes | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Gagging/Coughing | <input type="checkbox"/> Limping |
| <input type="checkbox"/> Gums Bleed | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Scooting | <input type="checkbox"/> Scratching |
| <input type="checkbox"/> Shaking Head | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Increased Thirst | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Increased Urination | <input type="checkbox"/> Weakness | <input type="checkbox"/> Dental Disorders | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Eye Disorders | <input type="checkbox"/> Ear Disorders | <input type="checkbox"/> Kidney Disorders | |
| <input type="checkbox"/> Other(Please explain) _____ | | | |

If your pet has been treated for any of the above, when and by whom _____

PET'S HISTORY (check all that pet has received):

DOGS: Who gave previous vaccines? _____

- Distemper/Parvo/DHLPPC/DHPPC Bordetella Rabies
 Porphyromonas Lyme Disease Leptospirosis H3N8 (K-9 Flu)
 Heartworm Test Other (please list): _____

Prior Surgeries: _____

Prior Illness: _____

CATS: Who gave previous vaccines? _____

- Distemper/FVRCP Feline Leukemia Feline Bordetella
 Rabies FIV/FeLV Test Heartworm Test
 Other (please list): _____

Prior Surgeries: _____

Prior Illness: _____