Pet's Medical History

PET'S NAME: BREED:

DATE OF BIRTH: SEX: NEUTERED: Y N

COLOR/MARKINGS:

PRIOR VETERINARY CLINIC: PHONE:

IS YOUR PET ALLERGIC TO ANY MEDICATIONS/VACCINATIONS?

DOES YOUR PET HAVE ANY SPECIAL MEDICAL CONDITIONS OR ON ANY MEDICATIONS?

Owner's Information

OWNERS NAME:
(Must be 18 years of age)

SOCIAL SECURITY NO:

SPOUSE/OTHER:

SPOUSE/OTHER'S SS#:

ADDRESS:

CITY: STATE: ZIP:

HOME PHONE:

CELL PHONE:

EMAIL ADDRESS:

CELL PHONE:

EMPLOYED BY:

WORK PHONE:

EMERGENCY CONTACT:

EMERGENCY PHONE:

Who else is allowed to bring pets in and make medical and financial decisions?

1) 2)

NOTE

We take pride in the quality of service and medical care we provide for your pet. In an effort to maintain these standards and keep your costs at a reasonable level, **WE DO NOT BILL FOR SERVICES PROVIDED.** Payment options are: CASH, CHECK, CREDIT CARD, CARE CREDIT, PREPAYMENT. I agree to pay for professional services and medications. The information on this form is true and accurate.

SIGNATURE _____ DATE _____