washington
ANIMAL • HOSPITAL

Client Information

Date: ______________

Owner: ______________________________

Address : ______________________________

City/State/Zip: ______________________________

Home Phone: ______________ Work Phone: ______________

Cell Phone: ______________ Email: ______________

Reason for visit: ______________________________

How did you hear about our practice? Internet ☐ Yellow Pages ☐ Sign/Location ☐
Township Newsletter ☐
Friend/Relative ☐ ______________
(Please provide their name so we can send them a thank you!)

Patient Information

Name: ______________ Dog ☐ Cat ☐ Other ______________

Breed: ______________

Male ☐ Neutered Male ☐ Female ☐ Spayed Female ☐

Date of Birth: ______________ Color: ______________

Vaccine / Procedure History:

Dog:	Date:	Cat:	Date:
Distemper (DA², DHPP, DHLPP) ☐	________	FVRCPC ☐	________
Rabies 1 year ☐ 3 year ☐	________	Rabies 1 year ☐ 3 year ☐	________
Lyme ☐	________	Leukemia ☐	________
4DX or Heartworm Test ☐	________	Leukemia/FIV Test ☐	________
Bordetella (Kennel Cough) ☐	________		
K-9 Influenza ☐	________		

Please check any symptoms or problems you've noticed with your pet:

Increased Urination ☐	Gagging/Coughing ☐	Sneezing ☐
Limping ☐	Scratching ☐	Shaking head ☐
Vomiting ☐	Diarrhea ☐	Appetite Loss ☐
Behavioral Changes ☐	Weakness ☐	Scooting ☐

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 client responsible for pet(s) ______________________ Date ____________