PATIENT CODE

ACQUAINTANCE INFORMATION

CLIENT CODE

Thank You for giving us the opportunity to care for your animal. Please complete the following so that we may become better acquainted.

CLIENT'S LAST NAME	FIRST NAME	DATE	X-RAY NO.

STREET ADDRESS	CITY/TOWN	PROV.	POSTAL CODE

SPOUSE	HOME PHONE	BUSINESS PHONE	CELL PHONE

How did you choose our practice/clinic? ❑ Phone book ❑ Location ❑ Referral ❑ Other _____

If personal recommendation, name of person: _____

PET INFORMATION

NAME _____ ❑ DOG ❑ CAT OTHER _____

BREED _____ COLOUR & MARKINGS _____

❑ **MALE** NEUTERED ❑ YES ❑ NO ❑ **FEMALE** SPAYED ❑ YES ❑ NO DATE OF BIRTH ____/____/____

WHAT WAS THE LAST KIND OF TREATMENT? (EXAM, SHOTS, ETC.) _____

MICROCHIP _____

PREVIOUS DOCTOR'S NAME _____

MAY WE REQUEST YOUR PET'S HEALTH RECORDS FROM PREVIOUS DOCTOR? ❑ YES ❑ NO

List any known drug allergies: _____

Is there a prior illness or surgery we should know about? _____

Currently, is there a special diet or medication being given? _____

- ALL FEES ARE DUE WHEN SERVICES ARE RENDERED -

Owner/Co-owner's signature _____ Date _____

PROBLEM LIST

1. _____ DATE
2. _____ DATE
3. _____ DATE
4. _____ DATE
5. _____ DATE
6. _____ DATE
7. _____ DATE
8. _____ DATE
9. _____ DATE
10. _____ DATE
11. _____ DATE
12. _____ DATE
13. _____ DATE
14. _____ DATE
15. _____ DATE
16. _____ DATE