



WELCOME! Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank you!

Client Information

Date: _____ Social Security Number _____ Birthdate: _____
 Name(s): _____ Cell Phone: () _____
 Address: _____ City/State/Zip: _____
 Home phone: () _____ Employer: _____
 Work phone: () _____ Employer Address: _____
 Emergency Contact Name: _____ Phone: () _____
 How did you learn about our practice? Drive by Yellow pages Humane Society
 Website Referred By SONO PAW DexiEMOYIE.com
 Number of pets (please specify by type): _____
 Primary reason for visit: _____
 *Email (please provide for Pet Portals): _____

Pet Information

Pet's Name: _____ Dog Cat Other _____
 Sex: Male Female Neutered or Spayed? Yes No At what age? _____
 Birthdate: _____ Breed: _____ Color: _____
 What age was pet obtained? _____
 From: Friend Breeder Pet Shop Humane Society Other: _____
 Reason for obtaining pet (check all that apply): Companion Protection Hunting
 Breeding Show Other: _____
 Describe your pet's diet: _____
 List your pet's current medication: _____

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Gagging | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Behavioral Changes | <input type="checkbox"/> Gums bleeding/bad breath | <input type="checkbox"/> Thirst |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Limping | <input type="checkbox"/> Urination Increase |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Scooting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | Other: _____ |
| <input type="checkbox"/> Eye Disorders: _____ | <input type="checkbox"/> Shaking Head | Other: _____ |

Pet's History (check all that pet has received):

- | | | |
|---|---|---|
| <input type="checkbox"/> Distemper (Dog/Ferret) | <input type="checkbox"/> Feline Leukemia Test | <input type="checkbox"/> Prior Surgery: _____ |
| <input type="checkbox"/> Parvovirus (Dog) | <input type="checkbox"/> FVRCP (Infectious Disease-Cat) | <input type="checkbox"/> Prior Illness: _____ |
| <input type="checkbox"/> Rabies (Dog/Cat) | <input type="checkbox"/> Dental | Other: _____ |

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 this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for inpatient treatment.

Signature of Owner: _____ Date: _____

Method of Payment: Cash Check MasterCard Visa Other: _____