Wales animal clinic
where paws are in good hands

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

Name(s): #1:_____ #2:_____ _____
Cell Phone #1: (____)_____Cell Phone #2: (____) _____
Address: _____ City/State/Zip:_____
Home phone:(___)_____Employer: _____
Work phone: (___)_____ Employer Address: _____
Non Owner Emergency Contact Name: _____Phone: (____)_____
*Email (please provide for your Pet Portals):_____

How did you learn about our practice? **0** Clinic Sign **0** Humane Society **0** Internet Ad
0 Yellow pages **0** Website **0** Referred By_____
Number of pets in household (please specify by type): _____
Primary reason for visit: _____

Pet Information

Pet's Name: _____ 0 Dog 0 Cat 0 Other _____
Sex: **0** Male **0** Neutered **0** Female **0** Spayed Altered at what age? _____
Birthdate: _____ Breed: _____ Color: _____
What age was pet obtained? _____
From: **0** Friend **0** Breeder **0** Pet Shop **0** Humane Society **0** Other: _____
Describe your pet's diet: **0** Kibble **0** Canned Brand: _____
List your pet's current medication(s): _____

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

0 Appetite Loss	0 Gagging	0 Sneezing
0 Behavioral Changes	0 Gums bleeding/bad breath	0 Thirst
0 Breathing Problems	0 Limping	0 Urination Increase
0 Coughing	0 Loss of Balance	0 Vomiting
0 Depression	0 Scooting	0 Weakness
0 Diarrhea	0 Scratching	0 Rash
0 Eye Disorders: _____	0 Shaking Head	0 Other: _____

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

0 Rabies (Dog/Cat) 0 Prior Surgery: _____
0 Dental 0 Prior Illness: _____
0 Allergies: _____
0 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 or special order medication.* Treatment plans always available by request.

Signature of Owner: _____ Date: _____

If you are ever unable to be present for your pet to receive veterinary care, you may authorize other to make medical decisions in your absence by indicating their names below:

Name(s):_____Phone:_____