CLIENT SATISFACTION SURVEY

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor

Professionalism Of Our Staff:

Cleanliness Of Our Facility:

Quality Of Services Received:

Overall Impression Of Our Practice:

Did You Have To Wait Past Your Scheduled Appointment Time?

Yes

No

If You Answered "Yes" To The Previous Question, Then Please Tell Us How Long You Had To Wait For Your Appointment:

Please Feel Free To Leave Us Any Additonal Comments:

Client Name:

Client Phone Number:

Alternative Phone Number:

Client E-mail Address:

Pet’s Name:

Name Of Medication To Be Refilled:

Quantity To Be Refilled:

Current Dosage Given:

Any Side Effects Seen?

Yes

No

Date Of Pet’s Most Recent Exam:

Additional Comments:

We Will Contact You After Your Request Has Been Reviewed By A Doctor.

Please Allow 24 To 48 Hours For Processing Of Your Request.

BOARDING REGISTRATION FORM

All Boarders MUST Have Up-To-Date Vaccinations!

Drop-Off Date Requested:

Pick-Up Date Requested:

Owner's Name:

Owner's Phone Number

Owner's Address:

Street 1:

Street 2:

City:

State:

Zip:

Pet's Name:

Emergency Contact Name:

Emergency Contact Phone Number:

Would you like your pet bathed?

Yes

No

List your pet's belongings:

How many times should we feed your pet per day?

Feed my pet in the:

AM

PM

Both

Will your pet receive his/her medications prior to arrival for boarding?

yes

no

Will you feed your pet prior to arrival for boarding?

yes

no

N/A

Please list any special instructions (include detailed medication directions and anything that you wish the doctor to check for)

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Conditions For Boarding My Pet And I Fully Intend To Pick Up My Pet On The Above Date Specified. If Circumstances Change, I Will Notify The Practice Of The New Pick-Up Date.

The hospital shall not be responsible for the loss, theft or destruction of any personal property left with the above pet.

Medical Illness Policy

Canyon Small Animal Hospital

NEW CLIENT INFORMATION FORM

Date:

Owner’s Name:

Owner’s Address:

Street 1:

Street 2:

City:

State:

Zip:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Employer:

Driver’s License Number:

Email Address:

How did you become aware of us?

Pet’s Name:

Pet’s Breed:

Pet’s Color:

Pet’s Sex:

Male

Female

option1

option2

	option1
	option2
Pet’s Date Of Birth:	
Date Of Most Recent Vaccinations:	
	Yes
May we contact your previous veterinarian for a records transfer?	No
	Not Applicable
	option1
	option2
Previous Clinic’s Name:	
	Street 1:
	Street 2:
Previous Clinic’s Address:	City:
	State:
	Zip:

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

DROP-OFF RELEASE FORM

Today’s Date:	
Owner’s Name:	
Owner’s Phone Number:	
	Street 1:
	Street 2:
Owner’s Address:	City:
	State:
	Zip:
Pet’s Name:	
Reason For Visit:	
Will Your Pet Be Fed Prior To Arrival?	Yes
	No
Is Your Pet On Heartworm Prevention?	Yes
	No

If You Answered "Yes" To The Previous Question And You Would Like To Refill Your Pet’s Heartworm Medication, Then Please Specify The Name Of The Desired Medication:	
Is Your Pet On Flea Prevention?	Yes No
If You Answered "Yes" To The Previous Question And You Would Like To Refill Your Pet’s Flea Prevention Medication, Then Please Specify The Name Of The Desired Medication:	
Has Your Pet Been Checked For Intestinal Parasites In The Last 6 Months?	Yes No
Has Your Pet Ever Had Any Reaction To Medications?	Yes No
Has Your Pet Ever Had Any Reaction To Vaccines?	Yes No
Has Your Pet Ever Had Any Reaction To Anesthesia?	Yes No
Is Your Pet Currently On Any Medication(s)?	Yes No
If "Yes", Please List The Name Of The Medication And The Dosage:	

HAS YOUR PET SHOWN ANY SIGN OF THE FOLLOWING?:

Vomiting?	Yes No

Diarrhea?	Yes No
Listless?	Yes No
No Appetite?	Yes No
Weakness?	Yes No
Coughing?	Yes No
Gagging?	Yes No
Scratching?	Yes No
Shaking Head?	Yes No
Scooting?	No Yes
Seizures?	Yes No
Abnormal Amount Of Urination?	Yes No
Abnorma Amount Of Drinking?	Yes No
Limping?	Yes No
Abnormal Weight Loss Or Gain?	Yes No
Unusual Lumps Or Bumps?	Yes No

TESTS & SERVICES TO BE PERFORMED DURING THIS VISIT:

Puppy/Kitten Wellness Exam

Annual Wellness Exam

Intestinal Parasite Exam

Deworm (If Needed)

Heartworm Test

FELVFIV Test

Bath

Grooming

Other (Please Specify):

Do authorize to take radiographs if necessary?

Yes

No

May We Sedate/Anesthesize Your Pet If Necessary?

Yes

No

By Clicking The "Submit" Button, I Agree With All Of The Following:The practice is to use all reasonable precaution against injury, escape, or death of my pet. The practice and staff WILL NOT be held liable for any problems that develop provided reasonable care and precautions are followed. I understand that ANY problem that develops with my pet while I'm absent will be treated as deemed best by the staff veterinarians and I ASSUME FULL RESPONSIBILITY for the treatment expense involved. I agree to pay fees for all services rendered at the time my pet is discharged from the practice or the service is otherwise terminated. I agree to pay for the reasonable costs of collection, attorneys fees and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the practice is located. If I neglect to pick up my pet within 7 days of the date below and do not notify the practice within that time frame, the practice may assume that the pet is abandoned and is hereby authorized to dispose of the pet as deemed best and/or necessary.

Client Name:

Client Name:

Client Phone Number:

Alternative Phone Number:

Client E-mail Address:

Pet's Name:

Name Of Medication To Be Refilled:

Quantity To Be Refilled:

Current Dosage Given:

Any Side Effects Seen?

Yes

No

Date Of Pet's Most Recent Exam:

Additional Comments:

We Will Contact You After Your Request Has Been Reviewed By A Doctor.

Please Allow 24 To 48 Hours For Processing Of Your Request.

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor

Professionalism Of Our Staff:

Cleanliness Of Our Facility:

Quality Of Services Received:

Overall Impression Of Our Practice:

Did You Have To Wait Past Your Scheduled Appointment Time?

Yes

No

If You Answered "Yes" To The Previous Question, Then Please Tell Us How Long You Had To Wait For Your Appointment:

Please Feel Free To Leave Us Any Additonal Comments:

Client Name:

Pet’s Name:

Client Phone Number:

Client E-mail Address:

Name Of Medication To Be Refilled:

Quantity To Be Refilled:

Current Dosage Given:

Any Side Effects Seen?

Yes

No

Date Of Pet’s Most Recent Exam:

Additional Comments:

Please Allow 24 To 48 Hours For Processing Of Your Request.

We Will Contact You After Your Request Has Been Reviewed By A Doctor.

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor

Professionalism Of Our Staff:

Cleanliness Of Our Facility:

Quality Of Services Received:

Overall Impression Of Our Practice:

Did You Have To Wait Past Your Scheduled Appointment Time?

Yes

No

If You Answered "Yes" To The Previous Question, Then Please Tell Us How Long You Had To Wait For Your Appointment:

Please Feel Free To Leave Us Any Additonal Comments:

NEW CLIENT INFORMATION FORM

Date:

Owner’s Name:

Owner’s Address:

Street 1:

Street 2:

City:

State:

Zip:

Email Address

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Employer:

Driver’s License Number:

How did you become aware of us?

Pet’s Name:

Pet’s Breed:

Pet’s Color:

Pet’s Sex:
- Male
- Male Neuter
- Female
- Female Spay

Pet’s Date Of Birth:

Date Of Most Recent Vaccinations:

May we contact your previous veterinarian for a records transfer?
- Yes
- No

Previous Clinic’s Name:

Previous Clinic’s Address:
- Street 1:
- Street 2:
- City:
- State:
- Zip:

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

NEW CLIENT INFORMATION FORM

NEW CLIENT INFORMATION FORM

Date:

Owner’s Name:

Spouse’ Name:

Mailing Address:
- Street 1:
- Street 2:
- City:
- State:
- Zip:

Physical Address:	Street 1:
	Street 2:
	City:
	State:
	Zip:
Best Contact Number:	
Home Phone Number:	
Cell Phone Number:	
Work Phone Number	
May we call you at work?	
E-Mail Address:	
Driver's License Number:	
How did you become aware of us?	
Pet #1	
Pet's Name:	
Pet's Species:	Canine Feline Other
Pet's Breed:	
Pet's Color:	
Pet's Sex:	
Pet's Date Of Birth:	
Date Of Most Recent Vaccinations:	
Does your pet(s) have any chronic health problems? (Kidney disease, heart disease, arthritis, diabetes, allergies, drug reactions, skin conditions, etc.)	Yes No
Please describe:	
Is your pet(s) currently taking medication or on a	Yes No

special diet?	
Please describe:	
Pet # 2	
Pet’s Name:	
Pet’s Species:	Canine Feline Other
Pet’s Breed:	
Pet’s Color:	
Pet’s Sex:	
Pet’s Date Of Birth:	
Date Of Most Recent Vaccinations:	
Does your pet(s) have any chronic health problems? (Kidney disease, heart disease, arthritis, diabetes, allergies, drug reactions, skin conditions, etc.)	Yes No
Please describe:	
Is your pet(s) currently taking medication or on a special diet?	Yes No
Please describe:	
Previous Clinic’s Name:	
May we contact your previous veterinarian for a records transfer?	Yes No Not Applicable
Previous Clinic’s Address:	Street 1: Street 2: City: State: Zip:

By clicking the "Submit" button, I certify that I assume responsibility for all charges incurred in the treatment and care of my animal(s). I also understand that

these charges will be paid at the time services are rendered and that a deposit may be required for surgery and hospitalization.

CLIENT SATISFACTION SURVEY

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor

Professionalism Of Our Staff:

Cleanliness Of Our Facility:

Quality Of Services Received:

Overall Impression Of Our Practice:

Did You Have To Wait Past Your Scheduled Appointment Time?

Yes

No

If You Answered "Yes" To The Previous Question, Then Please Tell Us How Long You Had To Wait For Your Appointment:

Please Feel Free To Leave Us Any Additonal Comments:

NEW CLIENT INFORMATION FORM

NEW CLIENT INFORMATION FORM

Date:

Owner’s Name:

Owner’s Address:

Street 1:

Street 2:

City:

State:

Zip:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Email Address:

Employer:

Driver’s License Number:	
How did you become aware of us?	
Pet’s Name:	
Pet’s Breed:	
Pet’s Color:	
Pet’s Sex:	Male Female option1 option2 option1 option2
Pet’s Date Of Birth:	
Date Of Most Recent Vaccinations:	
Previous Clinic’s Name:	
Previous Clinic’s Phone Number	
May we contact your previous veterinarian for a records transfer?	Yes No Not Applicable option1 option2 option1 option2

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor

Professionalism Of Our Staff:	
Cleanliness Of Our Facility:	
Quality Of Services Received:	

Overall Impression Of Our Practice:

Did You Have To Wait Past Your Scheduled Appointment Time?

Yes

No

If You Answered "Yes" To The Previous Question, Then Please Tell Us How Long You Had To Wait For Your Appointment:

Please Feel Free To Leave Us Any Additonal Comments:

NEW CLIENT INFORMATION FORM

NEW CLIENT INFORMATION FORM

Date:

Owner’s Name:

Owner’s Address:

Street 1:

Street 2:

City:

State:

Zip:

Home Phone Number:

Cell Phone Number:

Employer:

Work Phone Number:

Driver’s License Number:

How did you become aware of us?

Pet’s Name:

Pet’s Breed:

Pet’s Color:

Pet’s Sex:

Male

Female

Pet’s Date Of Birth:

Date Of Most Recent Vaccinations:

May we contact your previous veterinarian for a records transfer?	Yes No Not Applicable
Previous Clinic's Name:	

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

CLIENT SATISFACTION SURVEY

Date Of Your Visit:	
Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor	
Professionalism Of Our Staff:	
Cleanliness Of Our Facility:	
Quality Of Services Received:	
Overall Impression Of Our Practice:	
Did You Have To Wait Past Your Scheduled Appointment Time?	Yes No
If You Answered "Yes" To The Previous Question, Then Please Tell Us How Long You Had To Wait For Your Appointment:	
Please Feel Free To Leave Us Any Additonal Comments:	

Client and Patient Information

Today's Date:	
Owner's Name:	
Spouse's Name	
Owner's Address	Street 1: Street 2:

	City:
	State:
	Zip:
Home Phone Number:	
Cell Phone Number:	
Spouse’s Cell Phone Number:	
Work Phone Number:	
Spouse’s Work Phone Number:	
Emergency Contact:	
Emergency Contact’s Phone Number:	
E-mail Address	
Wouldn’t you like reminders e-mailed?	Yes No
Patient Name:	
Patient Species:	
Patient’s Date of Birth:	
Patient’s Sex:	
Patient’s Breed:	
Patient’s Coat Color:	
Does your pet have any medical conditions?	Yes No Unknown
If so, please explain:	
Is your pet on any medications?	Yes No
If so, which one(s)?	
How did you hear about us?	
If referred by a friend, who may we thank?	

We thank you for allowing us to take care of your pet. In order to provide the best possible care for your loved one, we require that all fees are due at the time services are rendered. We accept several payment options, including: cash, personal checks, debit cards, Visa, Discover, and American Express.Care Credit payment plans are gladly accepted. A receptionist will be happy to discuss this monthly payment plan with you. Approval from Care Credit is required.We routinely provide written

estimates. Critical patients that need extended hospitalization will have their balance updated daily. We are glad to work with you and give multiple estimates in order to help us provide the medical care that your pet may need. In the end, we always want what is best for you and your best friend. By clicking "Submit", you agree to the above terms and conditions.

NEW CLIENT INFORMATION FORM

Date:

Owner's Name:

Owner's Address:
- Street 1:
- Street 2:
- City:
- State:
- Zip:

Email Address

Home Phone Number:

Work Phone Number:

Cell Phone Number:

How did you become aware of us?

Employer:

Driver's License Number:

Pet's Name:

Pet's Breed:

Pet's Color:

Pet's Sex:
- Male
- Female
- Male Neutered
- Female Spayed

Pet's Date Of Birth:

Date Of Most Recent Vaccinations:

Previous Clinic's Name:

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

Client Name:

Client Phone Number:

Alternative Phone Number:

Client E-mail Address:

Pet’s Name:

Name Of Medication To Be Refilled:

Quantity To Be Refilled:

Current Dosage Given:

Any Side Effects Seen? Yes No

Date Of Pet’s Most Recent Exam:

Additional Comments:

Please Allow 24 To 48 Hours For Processing Of Your Request.

We Will Contact You After Your Request Has Been Reviewed By A Doctor.

Full Name

Pet’s Name

First Date Request

Second Date Request

1st Contact Phone Number

2nd Contact Phone Number

E-Mail Address

Reason for visit:

Appointment requests will be checked every 24-48 business hours. If you have an emergency or need immediate assistance please call the clinic direct at 407-892-3415. Thank You.

NEW CLIENT INFORMATION FORM

Date:

Owner’s Name:

Owner’s Address:

Street 1:

Street 2:

City:

State:

Zip:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Driver’s License Number:

How did you become aware of us?

Referral Client’s Name:

Pet’s Name:

Pet’s Breed:

Pet’s Color:

Pet’s Sex:
- Male
- Female
- Spayed Female
- Neutered Male

Pet’s Date Of Birth:

Date Of Most Recent Vaccinations:

Previous Clinic’s Name:

Previous Clinic’s Address:
- Street 1:
- Street 2:
- City:
- State:
- Zip:

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

BOARDING REGISTRATION FORM

Drop-Off Date Requested:

Pick-Up Date Requested:

Owner’s Name:

Owner’s Phone Number

Owner’s Address:
- Street 1:
- Street 2:
- City:
- State:
- Zip:

Pet’s Name:

Emergency Contact Name:

Emergency Contact Phone Number:

Would you like your pet bathed?

- Yes
- No
- option1
- option2

List your pet's belongings:

The hospital shall not be responsible for the loss, theft or destruction of any personal property left with the above pet.

How many times should we feed your pet per day?

Feed my pet in the:

- AM Only
- PM Only
- Both AM & PM

Tell us how much we should feed your pet:

Please list any special instructions (include detailed medication directions and anything that you wish the doctor to check for)

Will your pet receive his/her medications prior to arrival for boarding?

- Yes
- No

Any services needed while your pet is boarding with us?

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Conditions For Boarding My Pet And I Fully Intend To Pick Up My Pet On The Above Date Specified. If Circumstances Change, I Will Notify The Practice Of The New Pick-Up Date.

DROP-OFF RELEASE FORM

Today's Date:

Owner's Name:

Owner’s Phone Number:	
Owner’s Address:	Street 1: Street 2: City: State: Zip:
Pet’s Name:	
Reason For Visit:	
Is Your Pet On Heartworm Prevention?	Yes No
Is Your Pet On Flea Prevention?	Yes No Yes No Not Applicable option1 option2
If You Answered "Yes" To The Previous Question And You Would Like To Refill Your Pet’s Flea Prevention Medication, Then Please Specify The Name Of The Desired Medication:	
If You Answered "Yes" To The Previous Question And You Would Like To Refill Your Pet’s Heartworm Medication, Then Please Specify The Name Of The Desired Medication:	
Has Your Pet Been Checked For Intestinal Parasites In The	Yes No option1

Last 6 Months?	option2
	option1
	option2
	option1
	option2
Has Your Pet Ever Had Any Reaction To Medications?	Yes
	No
Has Your Pet Ever Had Any Reaction To Vaccines?	Yes
	No
	option1
	option2
Has Your Pet Ever Had Any Reaction To Anesthesia?	Yes
	No
	option1
	option2
Is Your Pet Currently On Any Medication(s)?	Yes
	No
	option1
	option2

HAS YOUR PET SHOWN ANY SIGN OF THE FOLLOWING?:

Vomiting?	Yes
	No
Diarrhea?	Yes
	No
Listless?	Yes
	No
No Appetite?	Yes
	No
Weakness?	Yes
	No
Coughing?	Yes
	No
Gagging?	Yes
	No
Scratching?	Yes
	No
Shaking Head?	Yes
	No

Scooting?	Yes No
Seizures?	Yes No
Abnormal Amount Of Urination?	Yes No
Abnorma Amount Of Drinking?	Yes No
Limping?	Yes No
Abnormal Weight Loss Or Gain?	Yes No
Unusual Lumps Or Bumps?	Yes No

TESTS & SERVICES TO BE PERFORMED DURING THIS VISIT:

Puppy/Kitten Wellness Exam	
Annual Wellness Exam	
Intestinal Parasite Exam	
Deworm (If Needed)	
Heartworm Test	
FELV Test	
FIV Test	
Bath	
If "Yes", Please List The Name Of The Medication And The Dosage:	
Other (Please Specify):	
May We Sedate/Anesthesize Your Pet If Necessary?	Yes No

By Clicking The "Submit" Button, I Agree With All Of The Following:The practice is to use all reasonable precaution against injury, escape, or death of my pet. The practice and staff WILL NOT be held liable for any problems that develop provided reasonable care and precautions are followed. I understand that ANY problem that develops with my pet while I’m absent will be treated as deemed best by the staff veterinarians and I ASSUME FULL RESPONSIBILITY for the treatment expense involved. I agree to pay fees for all services rendered at the time my pet is discharged from the practice or the

service is otherwise terminated. I agree to pay for the reasonable costs of collection, attorneys fees and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the practice is located. If I neglect to pick up my pet within 7 days of the date below and do not notify the practice within that time frame, the practice may assume that the pet is abandoned and is hereby authorized to dispose of the pet as deemed best and/or necessary.

Client Name:

Client Phone Number:

Alternative Phone Number:

Client E-mail Address:

Pet’s Name:

Name Of Medication To Be Refilled:

Quantity To Be Refilled:

Current Dosage Given:

Any Side Effects Seen? Yes No

Additional Comments:

We Will Contact You After Your Request Has Been Reviewed By A Doctor.

Please Allow 24 To 48 Hours For Processing Of Your Request.

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor

Professionalism Of Our Staff:

Cleanliness Of Our Facility:

Quality Of Services Received:

Overall Impression Of Our Practice:

Did You Have To Wait Past Your Scheduled Appointment Time? Yes No

If You Answered "Yes" To The Previous Question,

Then Please Tell Us How Long You Had To Wait For Your Appointment:

Please Feel Free To Leave Us Any Additonal Comments:

NEW CLIENT INFORMATION FORM

Date:

PATIENT INFORMATION

Pet’s Name:

Is Your Pet a Dog or Cat?	Dog Cat
Pet’s Date Of Birth:	
Pet’s Sex:	Male Female
Pet’s Breed:	
Pet’s Color:	
Is Your Pet Neutered or Spayed?	Yes No
At What Age was Your Pet Neutered or Spayed?	
Where Did You Obtain Your Pet?	Friend Breeder / Kennel Shelter / Humane Society Rescue Pet shop Stray
At What Age Did You Obtain Your Pet?	
Does Your Pet Have a Microchip?	Yes No
What Brand of Pet Food Does Your Pet Eat?	
Has Your Pet Received a Rabies Vaccine in the Past?	Yes No

If Your Pet is a Dog, Have They received a Distemper and Parvovirus (DHLP) Vaccine in the Past?	Yes No Not Applicable,My pet is a cat. Not Sure
If Your Pet is a Dog, Have They Received a Bordetella (Kennel Cough) Vaccine in the Past?	Yes No Not Applicable,My pet is a cat. Not Sure
If Your Pet is a Dog, Have They Received a Lyme Disease Vaccine in the Past?	Yes No Not Applicable,My pet is a cat. Not Sure
If Your Pet is a Cat, Have They Received an Upper Respiratory Vaccine (FVRCP) in the Past?	Yes No Not Applicable,My pet is a dog Not Sure
If Your Pet is a Cat, Have They Recieved a Feline Leukemia Vaccine in the Past?	Yes No Not Applicable,My pet is a dog Not Sure
Date Of Most Recent Vaccinations:	
If Your Pet is a Dog, Have They Previously Had a Heartworm Test?	Yes No Not Applicable,My pet is a cat. Not Sure
Date of Most Recent Heartworm Test:	
If Your Pet is a Cat,Have They Previously Been Tested for Feline Leukemia?	Yes No Not Applicable,My pet is a dog Not Sure
If Your Pet is a Cat, Have They Previously Been Tested for Feline Immunodefiency Virus (FIV)?	Yes No Not Applicable,My pet is a dog Not Sure

Date of Feline Leukemia and/or FIV Testing:

Has Your Pet Ever Had a Professional Teeth Cleaning?

Yes

No

Please Check the Monthly Heartworm Preventive that You Give Your Pet:

Sentinel

Revolution

Advantage Multi

Interceptor

Heartgard

Other

None

Date Last Heartworm Preventive Given:

Please Describe Any Prior Illness that Your Pet has had:

Please List any Surgeries Your Pet has had: (Spay,Neuter, and teeth cleanings not required to be listed)

Reason for Scheduled Visit:

Name of Previous Veterinarian: (If Applicable)

May we Contact Your Previous Veterinarian for Your Pet's Past Records?

Yes

No

CLIENT (owner) INFORMATION

Owner's Name:

Owner's Address:

Street 1:

Street 2:

City:

State:

Zip:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Driver’s License Number:

Social Security Number: (Required if checks will be written at the hospital)

Employer:

Occupation:

Business Phone Number

Business Address

Street 1:

Street 2:

City:

State:

Zip:

Name of Spouse or Co-Owner:

Spouse/Co-Owner Phone Number:

How did you become aware of us?

We will gladly prepare a written estimate of service fees if you desire. Please ask the receptionist or technician that assists you in the hospital.

All professional fees are due at the time of services rendered.

In the case of extensive medical or surgical procedures a deposit will be required upon admission and the remainder of the balance will be due at discharge.

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.