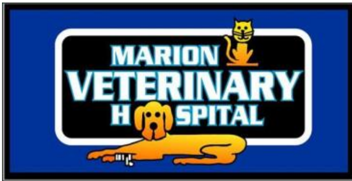

NEW PATIENT INFORMATION

www.yourvet.vetsuite.com

Visa • MasterCard • Discover • American Express • Care Credit

(Sorry, but we do not accept checks as a form of payment)

OWNER INFORMATION

Please note: Government-issued picture identification will be requested to verify identity for establishing an account.

Mr_____ Mrs_____Ms____Dr___Last Name___________________First______________________Initial________

Do you prefer to be referred by: First Name ______ or Last Name ______

Address: City, State: Zip:

Home( ) Cell( ) Work( ) ext

E-Mail address: (*we will send vaccine reminders to this address)

Employer: Emergency Contact/Number:

Co-Owner☐ or Spouse☐ Last Name______________________First______________________Initial________

Home( ) Cell( ) Work( ) ext

Please indicate how you heard of us: Phone Book☐ Internet☐ Sign☐ Humane Society☐ Dog Park ☐ Marquee☐

Referral – Whom may we thank?____________________________ Other________________________________

PATIENT(S) INFORMATION

Pet's Name:____________________________ Dog☐ Cat☐ Other:________________________________

Breed:_________________________________ Color:__________________________ Date of Birth:___________

Female☐ Spayed☐ Male☐ Neutered☐ **(please estimate if unknown)**

Is your pet the *best* pet in the whole world? Yes☐ No☐

I authorize the veterinarian(s) to examine, prescribe for, or treat the pet(s) listed above. I assume responsibility for all charges incurred in the care of this/these animals(s). I understand every reasonable effort will be made to provide for successful treatment; however, due to the nature of some conditions, no guarantee can be made of a successful outcome. I understand charges are to be paid at the time of services and a deposit may be required prior to treatment. I agree to pay interest charges of 18% APR (1.5% per month) for any balance over 30 days past due. Should collection efforts become necessary, I further agree to pay the reasonable costs incurred in the process of collections.

X____ ______________________________________

Signature of Owner of Financially Responsible Party Date

Comprehensive Patient Medical History Form

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Name of Pet:	Yes	No
Are your pet's vaccinations up to date?		
Has your pet ever had a reaction to vaccines?		
Was there a heartworm test in the last year?		
Is your pet taking a heartworm prevention Rx?		
Was your pet tested for worms in the last 6 months?		
Have you seen your pet passing any worms?		
Does your pet ever strain to urinate?		
Has your pet had any illness/injury in the last year?		
Has your pet ever had a seizure?		
Has there been any recent vomiting?		
Has there been any recent diarrhea?		
Any recent constipation?		
Has your pet been scooting?		
Has your pet been coughing?		
Sneezing?		
Gagging?		
Has your pet been listless?		
Have you noted any weakness?		
Any lameness: Indicate which leg: RF LF RR LR		
Have you noted any stiffness?		
Has your pet been scratching? Where?		
Have you noted any head shaking?		
Does your pet have any hair loss? Where?		
Any unusual lumps or bumps?		
Does your pet eat table scraps?		
Does your pet have bad breath?		
Is there any unusual discharge?		
Have you noted any behavioral changes?		
Does your pet travel with you?		
Increase or decrease in appetite?		
Increase or decrease in drinking?		
Increase or decrease in urination?		
Increase or decrease in Defecation?		
Increase or decrease in Weight?		

Please indicate the vaccines your **DOG** is current on:

Rabies YES NO **DHLPP** YES NO **Bordetella** YES NO
Lyme YES NO **Parvovirus** YES NO

Please indicate the vaccines your **CAT** is current on:

Rabies YES NO **FVRCP** YES NO **Feline Leukemia** YES NO
Does your cat live:
Indoors only Outdoors only Indoors & Outdoors

Reason for visit today?_____________________________

****Please bring your pet's medical history, if possible****
****Please bring with you any medications your pet is taking****
We will gladly make a copy for your pet's records.
If you cannot locate them, please list who has treated your pet(s) in the past so we can call to have the records faxed.

Veterinarian:

Phone:

Pet's diet?

Health problems or behavioral issues?

Is your pet allergic to any food or prescription? YES NO

Brand of flea and tick prevention?

Brand of heart worm prevention?

Anything else you would like us to know?

While uncommon, adverse reactions to vaccines, injections and medications can occur. Typical symptoms include swelling, itching and vomiting; however, in rare cases, collapse, seizures and death can occur. We encourage you to discuss any concerns you have regarding administering vaccines, injections or medications to your pet with one of our doctors.

I hereby authorize the hospital to prescribe for and treat the conditions presented on this form and requested in the future for my pet. The hospital and staff will not be held liable for any problems that develop provided that a reasonable standard of care is provided. Further, I agree to pay fees in full for services rendered when pet is discharged from the hospital's care unless prior arrangements have been agreed upon by both parties.

X___________________________ ____________
Signature Date