Animal Clinic of Chardon

CLIENT INFORMATION

Date:_____

Name (please print): _____ Spouse:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____Driver's License#_____

Emergency Contact Name: _____ Phone: _____

How did you hear about us?_____

Whom may we thank? (if a referral)_____

Where did you acquire your pet? _____

Please list all other pets in the household (names/species): _____

_____

PET HEALTH HISTORY

Name of pet: _____ □ Dog □ Cat □ Other_____

Sex: □ M □ F Age: _____ DOB: _____ Breed : _____

Color: _____ Neutered/Spayed: □ Yes □ No At what age: _____

Describe your pet's temperament: _____

Please check any symptoms or problems that you have noticed about your pet:

□ Coughing/Sneezing	□ Vomiting	□ Behavior Problems	□ Difficulty Breathing
□ Diarrhea	□ Eye Infections	□ Exercise Intolerance	□ Constipation
□ Scratching	□ Limping	□ Change in Thirst	□ Lumps or Bumps
□ Loss of Balance	□ Weakness	□ Change in Urination	□ Excessive Bleeding
□ Ear Infections	□ Bad Breath	□ Change in Appetite	□ Depressed

□ Previous medical conditions _____

□ Previous surgeries _____

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 the animal. I also understand that **payment is due at the time services are rendered** unless prior arrangements have been made.

Please inform us if an estimate is desired or there are any questions regarding our financial policy

Signature of owner _____ Date _____

Method of payment: □ Cash □ Check □ MC/Visa/American Express/Discover □ CareCredit

For Office Use: reviewed/updated

Initials	Date	Initials	Date	Initials	Date	Initials	Date	Initials	Date