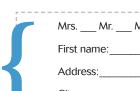
CLIENT INFORMATION FORM

Today's date:	/	/



Mrs Mr Ms Dr				
First name:	Λ	ΛI:	Last name:	
Address:				
City:	S	State:	ZIP:	
Home phone: ()	Work: ()		Cell: ()	Email:
How did you hear about us?				
Yellow Pages Newspaper _	Television Hospital	sign	Radio	
Personal recommendation	(Whom can we thank?)	
Other:				
Method of payment today				
Payment is required at the time of	of service. For your convenie	ence, we a	ccept Mastercard, Visa, Ame	rican Express, cash, or
check (with a valid driver's licens	e).			
Please check one: Cash 🚨 Che	ck ☐ Debit/Credit ☐			
How much information do you	want to be given about yo	ur pet's he	ealth?	
☐ I want a full explanation—any	thing and everything.			
☐ I want a brief explanation—jus	st the important stuff.			
☐ I just want to know if there's a	nything I need to do—keep	it simple.		
Consent				
You will be asked to sign a health	n plan confirming authorizat	tion of trea	tment after a tentative diagno	osis. The details of
treatment, the risks of treatment,	and/or the risk of not treati	ng will be	explained to you.	
Pet information				
Name:			Age/Birthday:	
Species (cat, dog, etc.)	Breed			
Color	Weight	Male	e 🗆 Female 🗅	
Spayed/neutered? Yes ☐ No [ב			
Does your pet have allergies? Y	es □ No □			
Has your pet ever had a reaction	to vaccines or medications	s? Yes 🗆	No □	
If yes, what?				
List any major surgeries your pet	thas had:			
List any behavior problems we n	eed to be aware of:			· · · · · · · · · · · · · · · · · · ·
	e your pet:			