Phelps Veterinary Hospital

CLIENT INFORMATION

Date: ______________________ Have you been to this hospital before? ___________

Name:_____________________________________ Significant Other: ____________________________

Address:___________________________________ PO Box _____ Home Phone: ____________________

City/State/Zip: ____ Cell Phone: _____________________

Work Phone: ________________________________ Significant Other Phone: __________________

Email Address: ______________________________ (Reminders will be sent via E-mail)

How did you hear about us? ____

Place of Employment (self): ____

Employment Address: ____

Place of Employment (spouse): ____

Employment Address: ____

All fees are due when services are rendered. How will you be paying? Cash Credit Card Check

PATIENT INFORMATION

Name:______________________ Date of Birth:___/___/____ Breed:____________ Color:______________

Sex: Male Female Spayed / Neutered: Yes No

Current medications:____

Current Diet:________________________ Has your pet traveled out of town?________________________

Did you bring a vaccination record? Yes No

Please circle any symptoms or problems that you have noticed in your pet:

- *Behavioral changes Depression*
- *Weight loss*
- *Weakness*
- *Loss of appetite*
- *Gagging*
- *Vomiting*
- *Diarrhea*
- *Breathing problems/coughing/sneezing*
- *Thirst*
- *Urination Increase*
- *Seizures*
- *Limping*
- *Loss of Balance*

AUTHORIZATION

I assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required at the time of service.

Signature: ______________________________________