



Client Information

Name: _____ Spouse/Other _____

Address: _____ City, State, Zip, County: _____

Home Phone: () _____ Work Phone: () _____

Cell phone: () _____ Employer: _____

Emergency Contact Name/Number: _____

Email: _____

How would you like to be contacted? ___ Email ___ Text ___ Phone ___ Standard Mail

All above information is kept strictly confidential and is used to ensure that your pet is discharged ONLY to you or your designated agent.

How did you learn about our practice? If you were referred by one of our existing clients, please let us know so we may thank them. ___ Individual: _____

___ Drive by ___ Internet Search ___ Newspaper ___ Event ___ Other: _____

Pet Information

Pet's Name: _____ Species ___ Dog ___ Cat ___ Other _____

Sex ___ Male ___ Female Neutered/Spayed ___ Yes ___ No

Age: _____ Birthdate: _____ Breed: _____ Color: _____

Is your pet on any special diets or medications (prescription, OTC, herbal)?

Previous Veterinarian: _____

Please check any symptoms or problems you've noticed with your pet:

___ Appetite Loss ___ Gagging ___ Sneezing ___ Behavioral Change ___ Bleeding Gums

___ Increased Thirst ___ Breathing Problems ___ Limping ___ Increased Urination

___ Coughing ___ Loss of Balance ___ Vomiting ___ Depression ___ Scooting

___ Weakness ___ Diarrhea ___ Scratching ___ Eye Problems ___ Shaking Head

Continued on the back...

Describe any:

Prior Illness _____ Prior surgery _____

Pet History (Check all pet has received):

Rabies Distemper (DHLPP/FVRCP) Bordetella (Kennel Cough)
 Canine Influenza Heartworm Test Fecal Feline Leukemia/FIV Test
 Feline Leukemia Vaccine (FELV)

Is your dog/cat currently on heartworm prevention? Yes No

Do you have pet insurance? Yes No

Reason for pet's visit _____

To prevent the spread of infectious diseases, all hospitalized patients must be current on all vaccines and free from internal and external parasites. The signature below authorizes this level of preventive care and the appropriate charges will be assessed in the discharge invoice.

I authorized the veterinarians and staff of Loving Hands Animal Clinic to examine, prescribe for and treat the above described pet. I am 18 years of age or older. I assume responsibility for all charges incurred in the care of the animal. I also understand that **ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED**. We accept: Cash, checks, Visa, MasterCard, American Express, Discover, and Care Credit.

Signature of client responsible for pet: _____ Date: _____

Welcome to Loving Hands Animal Clinic!

