PATIENT / CLIENT INFORMATION

Thank you for giving us the opportunity to care for your pet. Please help us meet your needs by taking a moment to complete both sides of this information sheet.

Owners Name		**Spouse/Other**
Address		**Phone ( )**
City	**Zip Code**	**County**
E-Mail		

Employer		
Address		
City	**Zip Code**	**Phone ( )**

At what time and at what phone number is best to call about your pet?
Time? **Phone**

We will gladly prepare an estimate if you desire. Please ask the receptionist or Doctor.
PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. If you plan to pay by check, please complete the following:

Drivers license number **State** **Expiration date**

How did you first hear about our hospital?
Referral from:

Individual	**Yellow Pages**
Groomer	**Hospital Sign**
Boarding Kennel	**Other**

Someone we may thank?

For your safety and your pet's health, the Animal Medical Clinic of St. Charles requires that all patients needing hospitalization be current on all vaccinations and free of internal and external parasites. We will notify you prior to hospitalization if any treatment is required.

Signature ______________________________ **Date** ________________

ANIMAL MEDICAL HISTORY

Please complete ALL information for each pet

PET INFORMATION	PET # 1	PET # 2	PET # 3
Name			
Species (dog, cat)			
Breed			
Color			
Age			
Date of birth			
Sex			
Neutered or Spayed			
Length of time owned			
MEDICAL HISTORY	Provide date of last:		
Canine			
Rabies			
Distemper			
Heartworm test			
Heartworm prevention			
Feline			
Rabies			
Distemper			
Leukemia			
Leukemia test			
GENERAL HEALTH			
Diet			
Vitamins			
Prior surgery / Dentistry			
Pet origin: (breeder, shelter, stray)			

Comments: