WELCOME
TO OUR PRACTICE

Client (owner) Information

Date: _____ Driver's License #: _____ Birthdate: _____

Name (Last Name First): _____ Spouse: _____

Address: _____ City, State, Zip: _____

Home Phone: (____) _____ Cell: (____) _____ Best place to reach you? _____

Work Phone: (____) _____ Employer: _____

Email Address: _____

Emergency Contact Name: _____ Phone: (____) _____

Number of pets in household (please specify type): _____

How did you hear about us? Please mark all that apply. Thank you.

☐ Friend or family (who may we thank?) _____ ☐ Local Shelter ☐ Family Coupons
☐ New Resident Ad ☐ Wellness Flyer ☐ Email Ad ☐ Referral Card ☐ Internet Search ☐ Billboard
☐ Walk/Drive By ☐ Phone Book ☐ Community Event _____ ☐ Other _____

Pet Information

Pet's Name: _____ ☐ Dog ☐ Cat ☐ Other _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ Breed: _____

Color: _____ Neutered/Spayed: ☐ Yes ☐ No At what age?: _____

What age was pet obtained?: _____ Microchip? ☐ Yes ☐ No Microchip #: _____

Obtained From: ☐ Friend ☐ Breeder ☐ Pet Shop ☐ Humane Society ☐ Other _____

Obtained pet for (check all that apply): ☐ Companion ☐ Protection ☐ Breeding ☐ Show ☐ Other _____

Describe your pet's diet: _____

List your pet's current medications: _____

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

☐ Appetite Loss	☐ Gagging	☐ Sneezing
☐ Behavioral Changes	☐ Thirst	☐ Scratching
☐ Breathing Problems	☐ Limping	☐ Urination Changes
☐ Coughing	☐ Loss of Balance	☐ Vomiting
☐ Scooting	☐ Weakness	☐ Other: _____
☐ Diarrhea	☐ Shaking Head	☐ Other: _____
☐ Eye Disorders: _____		

Pet's History (Check all that pet has received):

☐ Distemper	☐ Feline Leukemia Test	☐ Prior Surgery _____
☐ Parvovirus (Dog)	☐ FVRCP (Infectious Disease – Cat)	☐ Prior Illness _____
☐ Rabies (Dog/Cat)	☐ Dental	☐ Other: _____

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 ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Signature of client responsible for pet(s) _____ Date: _____

We look forward to having you as a part of our family here at Haven Animal Hospital! To improve your experience with us, we ask that you fill out the following information below and *e-mail it back to our practice* so we can promptly get you and your pet in to see the veterinarian!

Previous Veterinary Office Name:

Previous Vet Phone Number:

First & Last Name that your pet is under at previous clinic:

Any additional information you think we may need:

*** If your pet has been to multiple veterinary offices, please fill out the additional lines below.**

Previous Veterinary Office Name:
Previous Vet Phone Number:
First & Last Name that your pet is under at previous clinic:
Any additional information you think we may need:

Previous Veterinary Office Name:
Previous Vet Phone Number:
First & Last Name that your pet is under at previous clinic:
Any additional information you think we may need:

Previous Veterinary Office Name:
Previous Vet Phone Number:
First & Last Name that your pet is under at previous clinic:
Any additional information you think we may need:

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