ANIMAL MEDICAL CLINIC

2544 US Route 30, Hookstown, PA 15050

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely. We look forward to working with you in maintaining your pet's health. Thank you and WELCOME!!

Client Information

Date:_____ Driver's License:_____ Birthdate:_____
Name:_____Spouse _____
E-mail:_____

Address:_____ City, State, Zip:_____

Home Phone:_____ Cell Phone:_____

Occupation: _____ Work Phone:_____
Emergency Contact Name:_____ Phone:_____
How did you learn about our practice?:_____
If Referral list name:_____
Number of pets (Please specify by type):_____
Primary reason for visit:_____

Pet Information

Pet's Name:_____ Dog_____ Cat_____ Other _____Breed:_____
Sex: _____ (Neutered)_____ (Spay)_____ At what age:_____ Birthdate/Age:_____
Color:_____ Current Pet Food:_____
What age was pet obtained?:_____ From Whom:_____
Reasoning for obtaining pet (check all that apply): Companion_____ Protection _____Breeding_____
Show_____ Other_____Previous Veterinary Clinic:_____
List pet's current medication(s)/Including supplements:_____

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

_____Appetite Loss	_____Gagging	_____Sneezing
_____Behavioral Changes	_____Gums Bleeding	_____Thirst
_____Breathing Problems	_____Limping	_____Urinating Increase
_____Coughing	_____Loss of Balance	_____Vomiting
_____Depression	_____Scooting	_____Weakness
_____Diarrhea	_____Scratching	_____Other:_____
_____Eye Disorders:_____	_____Shaking Head	_____Other:_____

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

_____Distemper	_____Feline Leukemia Test	_____FDVR(Cat Distemper)
_____Parvovirus (Dog)	_____Prior Surgery:_____	
_____Rabies (Dog/Cat)	_____Prior Illness:_____	
_____Dental	_____Other:_____	

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above pet. I assume responsibility for all charges incurred in the care of this animal. **I also understand that these charges will be paid for in full the day services are rendered. A deposit will be required for surgical or emergency treatment. We do not accept payment plans.**

Signature of Owner_____Date_____

Method of Payment: Cash_____Credit Card (Type)_____Care Credit_____