



**GARDEN DISTRICT
PET HOSPITAL**

Date: _____

Client Information

Owner _____ Co-Owner _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Work Phone _____ Occupation _____

E-mail _____

In case of emergency, please contact _____

How Did you hear about us? _____

Pet Information

Pet's Name _____

Species (circle one): Dog / Cat / Other Breed _____

Sex (circle one) Male / Female Is your pet spayed or Neutered? Yes / No

Date of birth or approximate age _____ Color / Markings _____

How did you get your pet? _____

Date of last vaccinations? _____

Who could we call for previous vet records? _____

(Cats Only) Does your cat go outside? Yes / No

Number of other Pets in the household ____ Cats ____ Dogs ____ Other

Does your pet have any preexisting medical conditions?

Is your pet currently taking any medication (including heart worm or flea prevention)?

Is your pet allergic to any medications, food or vaccines?

Has your pet ever had any problems with anesthesia or surgery?

Reason for visit?

I, the undersigned, assume financial responsibility for all charges incurred, and agree to pay all such charges at the time these services are rendered or arranged prior to examination and / or treatment. A deposit may be required if surgery or hospitalization is required.

Signature_____Date_____