



# Welcome to our clinic!

We are glad to have the opportunity to care for your pet.  
To ensure your pet gets the best care we can offer, please fill out this form completely.

## Client Information:

Owner's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone Y / N Email: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ or Driver License #/ID \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Military: Y / N

Secondary Owner: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Number of pets in your household: Dogs \_\_\_\_\_ Cats \_\_\_\_\_ Other \_\_\_\_\_

I hereby give permission to share my pet's pictures on Animal General's website/social media: Y / N

## Pet Health History:

Pets Name: \_\_\_\_\_ Age/Birth date: \_\_\_\_\_

Type: Dog \_\_\_\_ Cat \_\_\_\_ Other \_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Sex: Male \_\_\_\_ Female \_\_\_\_ Neutered/Spayed: Yes \_\_\_\_ No \_\_\_\_ If yes, date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current medications your pet is taking: \_\_\_\_\_

Vaccination History:

Rabies: \_\_\_\_/\_\_\_\_/\_\_\_\_ Distemper/Parvo: \_\_\_\_/\_\_\_\_/\_\_\_\_ Bordetella: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary reason for visit: \_\_\_\_\_

Symptoms your pet is demonstrating:

\_\_\_\_ Behavioral Changes      \_\_\_\_ Appetite Loss      \_\_\_\_ Scooting      \_\_\_\_ Sneezing

\_\_\_\_ Increased Urination      \_\_\_\_ Loss of Balance      \_\_\_\_ Coughing      \_\_\_\_ Vomiting

\_\_\_\_ Breathing Problems      \_\_\_\_ Excessive Thirst      \_\_\_\_ Gagging      \_\_\_\_ Weakness

\_\_\_\_ Eye Disorders      \_\_\_\_ Bleeding Gums      \_\_\_\_ Depression      \_\_\_\_ Diarrhea

\_\_\_\_ Shaking Head      \_\_\_\_ Scratching      \_\_\_\_ Limping      \_\_\_\_ Other: \_\_\_\_\_

Prior Surgeries: \_\_\_\_\_

Prior Illnesses: \_\_\_\_\_

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 responsible party: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

The information on this form is strictly confidential and is to be used only by this practice to  
provide care and treatment for your pet.