

LAS POSAS VETERINARY MEDICAL CENTER

PATIENT/CLIENT INFORMATION SHEET

Date: _____

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

Client Information

_____	_____	_____	_____	_____
(Last name)	(First name)	(Spouse/Co-owner)		
_____	_____	_____	_____	_____
(Street address)	(City/State)	(Zip code)	(Home phone)	(Cell phone)
_____	_____	_____	_____	_____
(Employer)	(Work phone)	(Driver's license)	(Social security)	
_____	_____	_____	_____	_____
(Spouse's employer)	(Work phone)	(Spouse's driver's license)	(Spouse's social security)	
_____	_____	_____	_____	_____
(Emergency contact)	(Relationship)	(Phone number)		

How did you become aware of our hospital?

- Individual - Someone we may thank?: _____
 Phone Book Hospital sign Channel Islands Veterinary Hospital Welcome Wagon
 Direct mail Website Other _____

Would you like to be contacted about upcoming events/promotions/newsletter?: Yes No

E-Mail address : _____

Patient Information

_____	_____	_____	_____	_____	_____
(Name)	(Breed)	(Color)	(Date of birth)	(Sex)	(Neutered/Spayed)
<input type="checkbox"/> Feline	Vaccinations: FVRCP _____	FELV _____	Rabies _____		
	(Date)	(Date)	(Date)		
	FELV/FIV Test: _____	License No.: _____			
<input type="checkbox"/> Canine	Vaccinations: DHPP _____	Corona _____	Bordetella _____	Rabies _____	
	(Date)	(Date)	(Date)	(Date)	
	Heartworm Test: _____	License No.: _____			
Last physical exam _____	Last fecal parasite assay _____	Microchip No.: _____			
(Date)	(Date)				
Previous veterinarian: _____	_____	_____			
	(Name)	(Hospital / Clinic)			

Medical History

Patient concerns: _____

Past medical history: _____

Allergies: _____

Current medications: _____

PET LIFESTYLE SURVEY

(Please mark all that apply)

How long have you owned your pet?: _____

My pet is: High energy Easy going Inactive
 Indoor/Outdoor Indoor only

My pet goes on walks: Yes No How often?: _____

My pet is: Groomed professionally Bathed @ home
Every _____ weeks Every _____ weeks

My pet's nail's are trimmed: By a veterinarian By a groomer At home
How often?: _____

Monthly flea control used: Advantage Frontline Program Other: _____

When I travel, my pet: Goes with me Boards at a veterinary hospital
 Boards in a kennel Is taken care of by neighbor/family

My pet eats: Dry food Wet food Both Brand name: _____
 Other _____

My other pets are:	Names	Canine	Feline	Breed	DOB/Age
1)	_____	_____	_____	_____	_____
2)	_____	_____	_____	_____	_____
3)	_____	_____	_____	_____	_____
4)	_____	_____	_____	_____	_____

Emergency Contact

In case of an emergency and I am not present or able to be contacted, I authorize treatment for Patient named above and/or any other pets I own. I understand that I will be fully responsible for any charges incurred.

Authorization given: Yes No _____ (Signature) _____ (Date)

Note: If marked no or left blank, we can not render any medical attention until you are contacted and authorize us to do so.

Payment Information

Professional fees are to be paid at the time services are rendered. We do not carry open accounts but offer the following methods of payment: cash, local checks, Visa, MasterCard, Discover, and pre-approved credit through Wells Fargo Bank.

I understand that professional fees are to be paid at the time they are rendered. I authorize treatment for the patient named above and accept responsibility for charges incurred.

(Signature) _____ (Printed name) _____ (Date)

(Agent signature)

Hospital use only

File set up by: _____ Previous records received/reviewed: _____ Entered in Comp: _____

X-Ray: _____ Ultrasound: _____ Labwork: _____