ANTIETAM VALLEY ANIMAL HOSPITAL

"We strive for excellence in patient care"

Client Information

Name: (Last Name, First)_____

Address: _____ City/State/Zip:_____

Primary Contact #: (_____)_____ Secondary Contact #:(_____)_____

E-mail Address:_____

Employer: _____ Work Telephone: (____)_____

Spouse/Co-Owner: (Last Name, First) _____

Address: _____ City/State/Zip:_____

Primary Contact #: (_____)_____ Secondary Contact #:(_____)_____

E-mail Address:_____

Employer: _____ Work Telephone: (____)_____

Hospital Selection: □ Personal Referral □ Other _____

If referred by our client, please list name:_____

Number of Pets: ____ Canine(s) ____ Feline(s) ____ Exotic(s)

PRIMARY REASON FOR VISIT:_____

Pet Information

Pet's Name: _____ □ Canine □ Feline

Sex: □ Male □ Female Age:_____ Birthdate:_____Breed:_____

Color:_____ Neutered / Spayed: □ Yes □ No At What Age: _____

Pet obtained from: □ Friend □ Breeder □ Pet Shop □ Humane Society □ Other _____

Describe pet's diet:_____

List pet's current medication(s):_____

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

□ Appetite Loss	□ Depression	□ Gums Bleeding	□ Scratching	□ Urination Increase
□ Behavioral Changes	□ Diarrhea	□ Limping	□ Shaking Head	□ Vomiting
□ Breathing Problems	□ Eye Disorders	□ Loss of Balance	□ Sneezing	□ Weakness
□ Coughing	□ Gagging	□ Scooting	□ Thirst Increase	

□ Other: _____

Pet's History: (check all that apply)

□ Distemper/Rabies Vaccine □ Feline Leukemia/Aids test □ Dental

□ Microscopic Fecal Test □ Heartworm Test & Preventative

Prior Illness: _____

Prior Surgery: _____

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 understand that ***ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.***

_____ Date:_____

Signature of client responsible for pet 07/19