

CLIENT INFORMATION

Today's Date: ____/____/____

Owners Last Name: _____ Owners First Name(s): _____

Address: _____ City/State: _____ Zip: _____

Home Phone # () _____ - _____ Work # () _____ - _____ Cell # () _____ - _____

Spouse Name: _____ Work # () _____ - _____ Cell # () _____ - _____

Place of Employment: _____ Email (for reminders): _____

TxDL: _____ SSN: _____

How did you become aware of our Hospital?

Internet _____ Yellow Pages _____ Hospital Sign _____ Other: _____

Personal Recommendation (whom may we thank?) _____

PATIENT INFORMATION

PET'S NAME: _____ Species: (circle one) Canine / Feline

Breed: _____ Description/Color: _____

Date of Birth (Approx. Age): ____/____/____ (____)

Sex: (Circle one) MALE / FEMALE

Has this pet been spayed or neutered? (Circle one) Yes / No DATE: ____/____/____

Last Vaccination Date: ____/____/____

Vaccinations received:

See detailed questionnaire!

PAYMENT POLICY

I declare that I am the owner/agent of the pet listed above and at least 18 years old. I hereby authorize release of prior medical records. I agree to pay for services as they are rendered, and to pay my bill before my pet is discharged. In order to keep costs of professional services to a minimum, we DO NOT offer delayed payments. In the event that payment is not forthcoming, I agree to pay any collection, legal, and court fees, as well as interest at the standard acceptable rate. I authorize delinquent payments to be debited from my credit card on file or previously used (if applicable). Deposits may be required on major medical or surgical cases, trauma cases, and emergency work, where hospitalization may be required.

To prevent the spread of infectious diseases and parasites, all hospitalized or boarded animals must have official verification that they are current on all vaccines and free from parasites before entering the facility. I authorize Legacy Village Veterinary Clinic to provide vaccines and parasite control when no verification is provided or when parasites are noted.

SIGNATURE OF OWNER/AGENT:

DATE OF SIGNATURE: ____/____/____.

Cont.



Canine & Feline Patient History and Contact Addendum

Thank you for giving us the opportunity to care for your pet. So that we may better serve you, please take a minute to complete the following *optional* form.

Emergency Contact Information

Emergency Contact: _____
Emergency Contact Phone # (____) ____ - ____
Emergency Contact Email: _____@_____.com

Patient History

How long have you had your pet? _____
How did you acquire your pet? _____
Has your pet been seen previously at any other veterinary clinic(s)? Y/N
Clinic Name: _____ Phone # (____) ____ - ____
Does your pet have a microchip: Y/N Number (if known): _____
What Heartworm Preventative is your pet on? Brand: _____
What Flea/Tick Preventative is your pet on? Brand: _____
Diet: _____ Amount Fed (cups/day): _____
Do you give treats: Y/N If so, Brand/Amount: _____
Does your pet consume anything besides pet food? Y/N
Does your pet go outdoors? Y/N
Do you walk your pet? Y/N Does your pet use a Doggy Door? Y/N
How much time would you say your pet spends outdoors? _____
Does your pet go to and/or swim in any lakes, ponds, or creeks? Y/N
Does your pet associate with other animals (parks, grooming, boarding, training)? Y/N
Does your pet show aggression to other animals? Y/N People? Y/N
If so please explain: _____
Does your pet have any fears? _____
Does your pet travel with you? Y/N
If we think your pet is too cute, do you give us permission to use photos? Y/N

Please list any medications/supplements your pet is on at this time:

Name	Strength/Amount	Frequency

Please note any prior medical problems or conditions: _____

