New Patient Form

Patient Information

Pet's Name:_____ Canine[ ] Feline [ ] Breed:_____

Sex: Male [ ] Female [ ] Color:_____ Date Of Birth:_____

Spayed/ Neutered: Yes [ ] No [ ] Month/ Year Altered: _____

Vaccination History:
Indicate the date (mm/yy) your pet received the following core vaccines:

Canine:
Distemper/Parvo _____ Parvo_____ Bordetella_____ Rabies_____

Feline:
FVRCP_____ Leukemia_____ Rabies_____

Medical Records _____
Name of Hospital(s) where they can be obtained

Is your pet: Indoors Only[ ] Outdoors Only [ ] Both [ ]
Is your pet a working breed: Hunting [ ] Herding [ ] No [ ]
What type of food are you feeding your pet ? _____
Do you give you pet table scraps : Yes [ ] No [ ]
Do you give your pet treats: Yes [ ] No [ ] If yes, what type?_____

What do you use for flea control?_____ How often do you treat?_____
Is your pet on heart worm prevention? Yes [ ] No [ ] If yes, what kind?_____
Is your pet on any other parasite control? Yes [ ] No [ ] If yes, what kind?_____
Do you travel with your pet? Yes [ ] No [ ] Do you board or groom your pet? Yes [ ] No[ ]

Check Which Applies:
____ I feel that my pet is a member of our family
____ I feel that my pet is just a pet

____ I want the best medical care available for my pet.
____ I want good medical care for my pet, but there is a limit to what I am able to have done
____ I want only the services that I request for my pet.

____ I want to learn as much as I can about pet health, can you explain in detail what has been done for my pet or what is needed.
____ I would prefer you just summarized what has been done for my pet or what is needed.

____ I prefer to be present when my pet is examined and treated.
____ I would rather not be present when my pet is examined or treated.

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