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**AlaPalm Animal Hospital**

Thank you for giving us the opportunity to care for your pet. We’ll be happy to answer any questions you have about your pets health. To insure the best care possible, please take the time to fill in this form completely. Thank You!

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| New Client Information Sheet |

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Owner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_ Date: ­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Co-owner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? 🞏Drive By/Sign 🞏Facebook 🞏Website 🞏Referral Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Pet Information |

Pet’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**S**pecies: 🞏 Dog 🞏Cat 🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_

Breed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: 🞏Male 🞏Female 🞏Neutered Male 🞏Spayed Female

Please check any symptoms or problems that you have noticed about your pet:

🞏Behavior Problems 🞏Lack of Appetite 🞏Sneezing

🞏Bleeding Gums 🞏Limping 🞏Thirst and/or Urination Increased

🞏Breathing Problems 🞏Loss of Balance 🞏Vomiting

🞏Coughing 🞏Scooting 🞏Weakness

🞏Diarrhea 🞏Scratching 🞏Weight Gain/Loss

🞏Eye Bulging or Bloodshot 🞏Seems Depressed 🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏Gagging 🞏Shaking Head \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccine History: Please provide approximate dates (month/year) for:

 Dogs: DHPP\_\_\_\_\_\_\_\_\_ Corona\_\_\_\_\_\_\_\_\_ Bordetella\_\_\_\_\_\_\_\_\_\_ Rabies\_\_\_\_\_\_\_\_\_\_\_

 Cats: DRTC\_\_\_\_\_\_\_\_\_ Leukemia\_\_\_\_\_\_\_\_\_\_\_\_\_ Rabies\_\_\_\_\_\_\_\_\_\_\_\_ FeLV/FIV tested? 🞏Yes 🞏No

Is your pet: 🞏Indoors 🞏Outdoors 🞏Both

Do you have pet insurance? 🞏Yes 🞏No If yes, which provider? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in micro chipping your pet? 🞏Yes 🞏No Already has: #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your pet’s diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*If your pet has been seen elsewhere and you would like us to request your pet’s medical records on your behalf, please tell us the name and/or phone number of the veterinary hospital to contact:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Authorization |

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume full responsibility for all charges incurred in the care of this animal. I also understand that I will be given a preliminary estimate for all treatments and medications prior to starting treatment unless verbally approved. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_