WELCOME TO ESCANABA VETERINARY CLINIC

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following.

CLIENT INFORMATION Date ________________

Name____ Spouse's Name______________________________________

Address ____ City ________________________ State ______ Zip __________

Phone _________________________ Work Phone _______________________ Spouse's Work Phone ______________________

Place of Employment ____ Driver's License #___________________________

E-Mail Address ____Would you like to receive email reminders? **Y** or **N** (circle one)

How did you become aware of our clinic? Drove by Yellow Pages Previous Client

Personal Recommendation (Whom may we thank?) ____

PET HEALTH HISTORY

Name of pet ___________________________________ Dog Cat Other ___________________

Breed ____________________________________Color _____________________ Birthdate __________________________

Male Neuter Female Spayed

Vaccination History (Date and type of last vaccinations)____

____

Previous Veterinarian(s)____

Our pet(s) is: Member of our family Child's pet Backyard pet

Please check (✓) any symptoms or problems that you have noticed about your pet.

Behavior Problems
Bleeding Gums
Breathing Problems
Coughing
Diarrhea
Eye Bulging or Bloodshot
Gagging

Lack of Appetite
Limping
Loss of Balance
Scooting
Scratching
Seems Depressed
Shaking Head

Sneezing
Thirst and/or Urination Increased
Vomiting
Weakness
Other ______________________________

Pet's current medications ____

____

What do you feed your pet? ____

Any previous serious illnesses or surgeries? ____

Any allergies to vaccinations or medications? ____

Is your pet on any special diets or medications? ____

I herby authorize the veterinarian to examine, prescribe for, or treat the above-described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for emergency treatment.

Signature of Owner ____ Date ___________________

Please indicate choice of payment Cash / Check Visa MasterCard Care Credit