VETERINARIAN PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of .
Information collected about new patients is confidential and will be treated accordingly.

CLIENT INFORMATION

Name: _____

Street Address: _____

City: _____ **State**: _____ **Zip Code**: _____

E-Mail: _____ **Phone**: _____

Emergency Contact Name: _____ **Relationship**: _____

E-Mail: _____ **Phone**: _____

PET INFORMATION

Pet Name: _____ How long have you owned the pet: _____

Species: _____ **Breed**: _____

Color: _____ **Age:** _____

Gender: ☐ Male ☐ Female ☐ Unknown

Neutered/Spayed: ☐ Yes ☐ No ☐ Unknown

Exposure to outdoors: ☐ Indoor only ☐ Outdoor Exposure

Describe the pet's **travel history (five years)**:

MEDICAL INFORMATION

Name of **previous hospital**: _____ **Phone**: _____

List any known **vaccinations**: _____

List any current **allergies**: _____

List any current **medications**: _____

- Do you need a refill of any medications: ☐ Yes ☐ No

List any current **symptoms**:

Are the symptoms: ☐ Improving ☐ Worsening ☐ Stable

- When did you first notice the symptoms: _____

Has your pet been **sick previously**: ☐ Yes ☐ No

- Describe the issue/treatment:
-

Describe the pet's **current diet**: _____

- Has the appetite: ☐ Increased ☐ Decreased ☐ Unchanged

Do you want to be **notified with an estimate** before any diagnostics or treatments are performed? ☐ Yes ☐ No

SIGNATURE

Signature: _____ Date: _____

Print Name: _____