New Family Member

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

Pet Health History

Name of Pet:_____ Type of Pet:_____ Breed:_____

Color:_____ Date of Birth:_____ Sex:_____

Vaccination History: (Date and Type of last vaccinations)_____

_____

Pet's current medications:_____

Describe your pet's diet:_____

Describe your pet's lifestyle:_____

Please circle any symptoms or problems that you have noticed about your pet.

- ☐ Behavioral problems
- ☐ Limping
- ☐ Coughing
- ☐ Scratching
- ☐ Seems depressed
- ☐ Lack of appetite
- ☐ Breathing problems
- ☐ Scooting
- ☐ Eye bulging or bloodshot
- ☐ Thirst and/or urination increased
- ☐ Sneezing
- ☐ Loss of balance
- ☐ Weakness
- ☐ Gagging
- ☐ Bleeding gums
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Shaking head

Other_____

_____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and/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 surgical and/ or medical treatment. I agree by signature below failure to pay at time of service will cause late charges of 18% of balance to be assessed if not paid in full within 30 days. Balances that go over 30 days are subject to legal and collection proceedings. Necessary costs such as court fees, legal fees or any other fees incurred by D.C.A.H. in the collection of this account will be client's responsibility in full.

Signature:_____ Printed Name:_____

Method of Payment (please circle one): ◯ Cash ◯ Check Master card/Visa ◯ Other_____