

Dr. Diana Kuehn
 Dr. Olivia Seddon
 Dr. Roy Herren



8:00 a.m. - 5:30 p.m. M-F
 8:00 a.m. - noon Sat

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 _____ Cell Phone Number _____

Driver's License # _____ Social Security # _____ Date of Birth _____

E-Mail Address _____ Best Time To Reach You _____

All Fees Are Due At The Time Services Are Rendered

Please indicate choice of payment. Cash / Check Visa MasterCard American Express Discover

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

Personal Recommendation (*Whom may we thank?*) _____

PATIENT INFORMATION

	PET #1	PET #2	PET #3
NAME			
BREED			
DATE OF BIRTH OR AGE			
COLOR			
SEX: SPAYED OR NEUTERED?			
MICROCHIP			
YOUR DOG'S VACCINATION HISTORY			
RABIES			
DISTEMPER/PARVO/CORONA			
BORDETELLA			
FECAL (STOOL SAMPLE)			
HEARTWORM TEST/PREVENTION?			
YOUR CAT'S VACCINATION HISTORY			
RABIES			
DISTEMPER/UPPER RESP			
LEUKEMIA/FIV TEST			
LEUKEMIA VACCINATION			
FECAL (STOOL SAMPLE)			

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

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

Has your pet lived in another part of the country? Yes No If yes, where? _____

Would you like to be present during treatment to your pet? Yes No