



ANIMAL MEDICAL & SURGICAL HOSPITAL

WELCOME TO ANIMAL MEDICAL & SURGICAL HOSPITAL
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

Name _____ Spouse's Name _____ Date: _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____
 Place of employment _____ Spouse's Employer _____
 Work Phone _____ Spouse's Work Phone _____
 Cellular Phone _____ E-Mail Address _____
 Driver's License # _____ Social Security # _____
 Whom may we thank for referring you? _____
 Drove by Yellow Pages Previous Client

In order to provide services to you at the lowest possible cost, payment is expected at the time of treatment unless other arrangements have been made. We understand that payment is due at time of treatment.

Please indicate choice of payment: Cash/Check Visa MasterCard Discover Card Other Signature: _____

PATIENT INFORMATION

	Pet#1	Pet#2	Pet#3
Name	_____	_____	_____
Breed	_____	_____	_____
Date of birth	____/____/____	____/____/____	____/____/____
Color	_____	_____	_____
Sex: female female / spayed	_____	_____	_____
Sex: male male / neutered	_____	_____	_____

Name of your previous veterinarian _____

Any previous serious illness or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

Is your pet on Heartworm Prevention? _____

	Yes	No	Yes	No	
Any stiffness or difficulty standing or walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is your pet eating and drinking normally?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any hair loss or itching? <input type="checkbox"/> <input type="checkbox"/>
Is your pet urinating/defecating inappropriately?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is your pet having bad breath? <input type="checkbox"/> <input type="checkbox"/>
Have your pet's habits changed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your pet get tired easily? <input type="checkbox"/> <input type="checkbox"/>
Is your pet having any vomiting/ diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is your pet.....100% indoor mostly indoor mostly outside
Is your pet coughing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What diet is your pet on? _____
					Any other concerns? _____

Please, let us know if you would like further information about:

Flea/ tick control Boarding Surgeries Diets Other Services

Thank you for choosing AMSH for your pet's veterinary care. If you like us, let your friends know. If you have any suggestions for ways we can improve, let us know. animalmedicalsurgicalhospital@gmail.com