

# CHANNEL ISLANDS VETERINARY HOSPITAL

## PATIENT/CLIENT INFORMATION SHEET

Date: \_\_\_\_\_

Thank you for giving us the opportunity to care for your pet. Please help us better meet your needs by taking a moment to complete both sides of this information sheet.

### Client Information

_____	_____	_____	_____	_____
(Last name)	(First name)	(Spouse/Co-owner)		
_____	_____	_____	_____	_____
(Street address)	(City/State)	(Zip code)	(Home phone)	(Cell phone)
_____	_____	_____	_____	_____
(Employer)	(Work phone)	(Driver's license)	(Social security)	
_____	_____	_____	_____	_____
(Spouse's employer)	(Work phone)	(Spouse's driver's license)	(Spouse's social security)	
_____	_____	_____	_____	_____
(Emergency contact)	(Relationship)	(Phone number)		

How did you become aware of our hospital?

- Individual - Someone we may thank?: \_\_\_\_\_  
 Phone Book    Hospital sign    Las Posas Veterinary Medical Center    Welcome Wagon  
 Direct mail    Website    Other \_\_\_\_\_

Would you like to be contacted about upcoming events/promotions/newsletter?:  Yes    No

E-Mail address : \_\_\_\_\_

### Patient Information

_____	_____	_____	_____	_____	_____
(Name)	(Breed)	(Color)	(Date of birth)	(Sex)	(Neutered/Spayed)
<input type="checkbox"/> Feline	Vaccinations: FVRCP _____	FELV _____	Rabies _____		
	(Date)	(Date)	(Date)		
	FELV/FIV Test: _____	License No.: _____			
<input type="checkbox"/> Canine	Vaccinations: DHPP _____	Corona _____	Bordetella _____	Rabies _____	
	(Date)	(Date)	(Date)	(Date)	
	Heartworm Test: _____	License No.: _____			
Last physical exam _____	Last fecal parasite assay _____	Microchip No.: _____			
(Date)	(Date)				
Previous veterinarian: _____	_____	_____			
	(Name)	(Hospital / Clinic)			

### Medical History

Patient concerns: \_\_\_\_\_

Past medical history: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current medications: \_\_\_\_\_

# PET LIFESTYLE SURVEY

(Please mark all that apply)

How long have you owned your pet?: \_\_\_\_\_

My pet is:  High energy  Easy going  Inactive  
 Indoor/Outdoor  Indoor only

My pet goes on walks:  Yes  No How often?: \_\_\_\_\_

My pet is:  Groomed professionally  Bathed @ home  
Every \_\_\_\_\_ weeks Every \_\_\_\_\_ weeks

My pet's nail's are trimmed:  By a veterinarian  By a groomer  At home  
How often?: \_\_\_\_\_

Monthly flea control used:  Advantage  Frontline  Program  Other: \_\_\_\_\_

When I travel, my pet:  Goes with me  Boards at a veterinary hospital  
 Boards in a kennel  Is taken care of by neighbor/family

My pet eats:  Dry food  Wet food  Both Brand name: \_\_\_\_\_  
 Other \_\_\_\_\_

My other pets are:	Names	Canine	Feline	Breed	DOB/Age
1)	_____	_____	_____	_____	_____
2)	_____	_____	_____	_____	_____
3)	_____	_____	_____	_____	_____
4)	_____	_____	_____	_____	_____

## Emergency Contact

In case of an emergency and I am not present or able to be contacted, I authorize treatment for  Patient named above  and/or any other pets I own. I understand that I will be fully responsible for any charges incurred.

Authorization given:  Yes  No \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)

Note: If marked no or left blank, we can not render any medical attention until you are contacted and authorize us to do so.

## Payment Information

Professional fees are to be paid at the time services are rendered. We do not carry open accounts but offer the following methods of payment: cash, local checks, Visa, MasterCard, Discover, and pre-approved credit through Wells Fargo Bank.

I understand that professional fees are to be paid at the time they are rendered. I authorize treatment for the patient named above and accept responsibility for charges incurred.

\_\_\_\_\_  
(Signature) \_\_\_\_\_ (Printed name) \_\_\_\_\_ (Date)  
\_\_\_\_\_  
(Agent signature)

Hospital use only

File set up by: \_\_\_\_\_ Previous records received/reviewed: \_\_\_\_\_ Entered in Comp: \_\_\_\_\_

X-Ray: \_\_\_\_\_ Ultrasound: \_\_\_\_\_ Labwork: \_\_\_\_\_