

Pets and Vets as Partners



1220 Montgomery St
 West Lafayette, IN 47906
 (765) 463-7877
 www.petsandvetsaspartners.com

Welcome to Our Clinic

Today's Date: _____

Name: _____ Spouse/Other Name: _____

Children's Names/ages: _____

Street: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Work Phone: _____

Other Phone (Please specify): _____ Employer: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

E-mail Address: _____ Social Security Number: _____

Emergency Contact Name/Number: _____

Best time to call you regarding your pet's care: _____

Do you have more than one pet? If so, please list all pets below.

<u>Name (Start with today's patient):</u>	<u>Color</u>	<u>M/F</u>	<u>Breed</u>	<u>Neuter/Spayed</u>		<u>Age & DOB</u>	<u>Date of Last Vaccinations</u>
_____	_____	_____	_____	Yes	No	_____	_____
_____	_____	_____	_____	Yes	No	_____	_____
_____	_____	_____	_____	Yes	No	_____	_____
_____	_____	_____	_____	Yes	No	_____	_____
_____	_____	_____	_____	Yes	No	_____	_____
_____	_____	_____	_____	Yes	No	_____	_____
_____	_____	_____	_____	Yes	No	_____	_____

How did you hear about us?

Referral by Friend, Relative, etc (Whom shall we thank?): _____

Yellow Pages : _____

Sign (drove by): _____

Newspaper Ad: _____

Other: _____

Check any of the following that are of concern to you regarding your pet's behavior/health:

Excessive barking Straying from home

House Breaking Itching/Scratching

Wetting/Spraying in the house Overly excitable

Problems around children Biting

Shedding Clawing or digging

Jumping Bad Breath

Soiling outside the litterbox

Other: _____

How do you view your pet(s) in terms of overall health concerns/issues?

As a family member (I am concerned about all health issues/recommendations)

As a pet (I am not concerned about all preventative and wellness issues)

Which of the following services might you utilize:

Lodging/boarding facility Evening hours

Referral rewards program Other: _____

Puppy Kindergarten

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Name of Pet _____

Is your pet spayed or neutered?	No	Yes
If not, do you plan to have it done?	No	Yes
Do you plan to breed your pet?	No	Yes
Does your pet have any drug allergies?	No	Yes
Did you bring previous medical records?	No	Yes
Do you take your pet with you on vacation?	No	Yes
Will you ever need to board your pet?	No	Yes
Do you use your pet for hunting?	No	Yes
Is your pet on a preventative program for controlling internal parasites (heartworm, roundworm, hookworm, etc)?	No	Yes
Is your pet on a preventative program for controlling external parasites (fleas and ticks)?	No	Yes
Does your pet spend long periods of time alone during the day?	No	Yes
Has your pet been micro-chipped or tattooed?	No	Yes
Has your pet ever had dental care?	No	Yes
Do you understand the health benefits and life extending effects of providing proper dental care for pets?	No	Yes
Do you have veterinary pet insurance?	No	Yes

Where did you get your pet? _____
How long have you owned your pet? _____
What food does your pet eat? _____
Canned or dry? _____
Is your pet fed any table scraps (people food)? Yes No
How often do you bathe/brush your pet? _____
How much time does your pet spend outdoors? _____
Where does your pet sleep? _____
How much time does a family member spend with your pet per day? _____
What prior illness or health issues has your pet had? _____

Senior Care Health Check List (Pets over 7 years old)

Difficulty climbing stairs?	No	Yes	Excessive barking?	No	Yes
Difficulty jumping up?	No	Yes	Less interaction with family?	No	Yes
Increased stiffness or limpness?	No	Yes	Decreased responsiveness?	No	Yes
Loss of housetraining?	No	Yes	Tremors or shaking?	No	Yes
Increased thirst?	No	Yes	Skin or haircoat changes?	No	Yes
Increased urination?	No	Yes	Changes in sleeping patterns?	No	Yes
Changes in activity level?	No	Yes	Less enthusiastic greeting or behavior?	No	Yes
Excessive panting?	No	Yes	Altered appetite?	No	Yes
Circling/Repetitive movements?	No	Yes	Weight change?	No	Yes
Confusion or disorientation?	No	Yes	Other: _____		

Method of payment for today's visit: Cash ___ Check ___ Visa/MC ___

I acknowledge and accept full financial responsibility for all services rendered. I understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. There will be a \$20.00 fee on returned checks. I understand that any balance past due will include a finance charge of 21% and may be placed with a collection agency. I agree to pay the 35% collection fee. In the event of legal action, I agree to pay reasonable attorney fees and court costs.

Owner or Responsible Party: _____