



WELCOME

New Patient Information Form

Welcome to Valley View Pet Health Center. Our staff is dedicated to patient care and will do its utmost to make your pet's stay pleasant and beneficial. Please feel free to ask any questions concerning the treatment of your pet or other policies of the clinic. To help us serve you better, please provide us with the following information.

Personal Information

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Spouse's Work Phone _____

Cell Phone _____ Email Address _____

Best time to reach you during the day _____ Drivers License # _____

How did you choose our practice? Yellow Pages ___ Location ___ Other _____

Personal recommendation (whom may we thank?) _____

Our Pet is: Member of family ___ Child's Pet ___ Backyard Pet ___

Previous Veterinarian Information: Name _____

Hospital _____ Phone _____ Fax _____

Pet Health History

Reason for Visit _____

Any previous illnesses or surgeries? _____

Any Allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

	Pet #1	Pet #2	Pet #3
Name			
Breed			
Date of Birth			
Color			
Sex			
Spayed or Neutered (Yes/No)			
Last Heartworm Prevention			

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

- | | | | |
|---------------------|-------------------|-----------------------|--------------------|
| Bad Breath | Behavior Problems | Bleeding Gums | Breathing Problems |
| Coughing/Gagging | Diarrhea | Eye irritated/injured | Lack of appetite |
| Limping | Loss of balance | Scotting | Scratching |
| Seems Depressed | Shaking head | Sneezing | Thirst increased |
| Urination increased | Vomiting | Weakness | Weight loss |
| Weight Gain | | | |

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I understand that these charges must be paid at the time of release and that a deposit may be required for surgical treatment.

Signature: _____ **Date:** _____

Method of Payment: Cash ___ Check ___ MasterCard ___ VISA ___ Other ___