HARMONY
PET CLINIC
where pets feel at home

WELCOME! Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank you!

Client Information

Name(s): #1:_____ #2:_____
Cell Phone #1: (____)_____Cell Phone #2: (____)_____
Address: _____ City/State/Zip:_____
Home phone: (_____)_____ Employer: _____
Work phone: (_____)_____ Employer Address: _____
Non Owner Emergency Contact Name: _____Phone: (____)_____
How did you learn about our practice? ☐ Drive by ☐ Yellow pages ☐ Humane Society
☐ Website ☐ Referred By (Whom can we Thank?)_____
Number of pets in household (please specify by type): _____
Primary reason for visit: _____
*Email (please provide for your Pet Portals):_____

Pet Information

Pet's Name: _____ ☐ Dog ☐ Cat ☐ Other _____
Sex: ☐ Male ☐ Neutered ☐ Female ☐ Spayed Altered at what age? _____
Birthdate: _____ Breed: _____ Color: _____
What age was pet obtained? _____
From: ☐ Friend ☐ Breeder ☐ Pet Shop ☐ Humane Society ☐ Other: _____
Reason for obtaining pet (check all that apply): ☐ Companion ☐ Protection ☐ Hunting
☐ Breeding ☐ Show ☐ Other: _____
Describe your pet's diet: ☐ Kibble ☐ Canned Brand:_____
List your pet's current medication(s): _____
List any behavioral problems we should be aware of: _____
Has your pet ever had a reaction to vaccines or medications? ☐ Yes ☐ No If Yes, what? _____

Please check any symptoms or problems you've noticed with your pet:

☐ Appetite Loss	☐ Gagging	☐ Sneezing
☐ Behavioral Changes	☐ Gums bleeding/bad breath	☐ Thirst
☐ Breathing Problems	☐ Limping	☐ Urination Increase
☐ Coughing	☐ Loss of Balance	☐ Vomiting
☐ Depression	☐ Scooting	☐ Weakness
☐ Diarrhea	☐ Scratching	☐ Rash
☐ Eye Disorders: _____	☐ Shaking Head	

☐ Other: _____

Pet's History (check all that pet has received):

☐ Distemper (Dog/Ferret)	☐ Feline Leukemia Test	☐ Prior Surgery: _____
☐ Parvovirus (Dog)	☐ FVRCP (Infectious Disease-Cat)	☐ Prior Illness: _____
☐ Rabies (Dog/Cat)	☐ Dental	☐ Other: _____

☐ Allergies: _____

Authorization

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 also understand that these charges will be paid at the time of release and that a deposit may be required for inpatient treatment.

Signature of Owner: _____ Date: _____

Method of Payment: ☐ Cash ☐ MasterCard (Credit/Debit) ☐ Visa (Credit/Debit) ☐ Discover (Credit/Debit) ☐ AmEx ☐ Care Credit
Cash, Credit Card or Care Credit, are the preferred methods of payment ☐ Check (with proper ID)