

VETERINARY ASSOCIATES STONEFIELD

PATIENT/CLIENT INFORMATION

Thank you for giving us the opportunity to care for your pet. Please help us meet your needs by taking a few moments to fill out this information sheet.

Owner's Name _____ Spouse/other _____

Mailing Address _____ City/State/Zip _____

Home# _____ Work # _____

Cell Phone # _____ Spouse's Cell# _____

Email Address _____

Preferred method of Communication: Home# ____, Cell # ____, Email ____, Work# ____, SMS ____, Voice ____

Date of Birth _____ Owner's SSN _____

Employer's name / address _____

In Case of EMERGENCY, call _____ at phone# _____

We will gladly prepare a written estimate if you so desire. Please ask a receptionist or doctor. Professional fees are due at time services are rendered. If you wish to pay by check or credit card, please complete the following.

Bank Name: _____ Driver license # _____

Preferred method of Payment: Cash Check Credit Card

All information obtained will be kept on file for up to four years. Under HEPA laws any information will be kept in strict confidence and will not be shared or sold to any other parties.

Name of your previous/ current Veterinarian: _____

How did you hear of our Hospital? Please choose one?

- Individual, someone we may thank? _____
- Previous client? Their name. _____
- Yellow pages or another telephone directory? _____
- Hospital sign? _____
- Internet Search Engine? Which one? _____
- Another Hospital? Which one? _____
- Other, please state: _____

To help prevent the spread of infectious diseases, all hospitalized and boarded animals must be current on all vaccines.

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed on the next page. Furthermore, I agree to pay fees for services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection in the event that collection effort becomes necessary.

Signature _____ Date _____

EXOTIC PATIENT HISTORY

Pet's name _____

Bird _____ Mammal _____ Reptile _____ Other _____

Breed _____ Birth Date _____ Sex _____

How long has the patient been ill? _____

Are there any other animals at home? _____

If so, what type? _____

Are they showing any signs of illness? _____

Have any animals died? _____ Have any medicines been used? _____

Microchipped? _____

If so, what kinds? _____

Has the patient been last seen by another veterinarian? _____

If so, by whom, date last seen, and what for? _____

What food is used on a daily basis? _____

What type of water is used? _____

How often are food and water bowls changed and disinfected? _____

Where did the patient come from? _____

How long has the patient been in its present environment? _____

When was the last molt? _____

Have any pesticides or poisonous products been used around the cage? _____

If so, what? _____

Is the bird housed in a cage, allowed to free flight within the house, or housed in a flight pen? _____

Have you seen any personality/ behavioral changes? _____

Is there any other information that we may find helpful in treating your pet? _____

What is the nature of your visit? _____