

WELCOME TO FAMILY PET CLINIC

"Compassionate care for people and their pets."

CLIENT INFORMATION

Please print clearly and provide ALL of the following information (if applicable):

Owners name: _____ Please circle one: Mr. Mrs. Ms. Dr.

Physical Address: _____
City State Zip

Mailing Address: _____
City State Zip

Primary Phone #: _____ Text? Yes No Secondary Phone #: _____

Employer: _____ Work phone #: _____

E-mail: _____ (By providing an E-mail address you allow FPC to send you newsletters, updates, vaccine and wellness reminders, appointment confirmations, monthly specials, other important information, and your pet(s) medical records by request.)

DL# or SS#: _____ Co-Owner Name/emergency contact: _____

A Form of ID is required for your pet to be seen

Relationship to owner: _____ Contact #: _____

How did you find us? Internet search Drive-by Facebook Newspaper Other: _____
 Referral: _____

(Please provide us with the first and last name of the person who referred you to our clinic. As a thank you, we would like to apply a \$15.00 credit to their account.)

PET INFORMATION

PET INFORMATION						
PET'S NAME	SPECIES	BREED	COLOR	AGE or DOB	SEX	SPAY or NEUTER
	Dog Cat				Male Female	Yes No
ALLERGIES: <input type="checkbox"/> NONE <i>Check all that apply:</i> <input type="checkbox"/> Environmental <input type="checkbox"/> Medicines <input type="checkbox"/> Vaccines <input type="checkbox"/> Food <input type="checkbox"/> Other: _____ MEDICAL CONIDITIONS: <input type="checkbox"/> NONE Other medical conditions: _____ Microchipped: <input type="checkbox"/> Yes <input type="checkbox"/> No						
PET'S NAME	SPECIES	BREED	COLOR	AGE or DOB	SEX	SPAY or NEUTER
	Dog Cat				Male Female	Yes No
ALLERGIES: <input type="checkbox"/> NONE <i>Check all that apply:</i> <input type="checkbox"/> Environmental <input type="checkbox"/> Medicines <input type="checkbox"/> Vaccines <input type="checkbox"/> Food <input type="checkbox"/> Other: _____ MEDICAL CONIDITIONS: <input type="checkbox"/> NONE Other medical conditions: _____ Microchipped: <input type="checkbox"/> Yes <input type="checkbox"/> No						
PET'S NAME	SPECIES	BREED	COLOR	AGE or DOB	SEX	SPAY or NEUTER
	Dog Cat				Male Female	Yes No
ALLERGIES: <input type="checkbox"/> NONE <i>Check all that apply:</i> <input type="checkbox"/> Environmental <input type="checkbox"/> Medicines <input type="checkbox"/> Vaccines <input type="checkbox"/> Food <input type="checkbox"/> Other: _____ MEDICAL CONIDITIONS: <input type="checkbox"/> NONE Other medical conditions: _____ Microchipped: <input type="checkbox"/> Yes <input type="checkbox"/> No						

Any additional services/products today? Heartworm Test Nail Trim Anal Gland Expression Microchip Ear Cleaning Information and/or purchase of preventatives

My signature and initials below confirm the following:

(Initial) _____ I grant FPC permission to request past medical history from a previous veterinary clinic at which my pet(s) received treatment.

Name of Clinic: _____ #: _____

(Initial) _____ I authorize FPC to release medical information to other hospitals, groomers, and kennel facilities, thus waiving confidentiality of said medical record.

(Initial) _____ I grant FPC permission to post my pets' pictures and/or story on the hospital's social media accounts, thus waiving confidentiality of said medical record.

(Initial) _____ I authorize FPC to release basic contact information, such as my phone number, in the event my animal is lost and recovered by another individual.

I authorize Dr. Rena M. Dunahoo or attending veterinarian to examine, prescribe for, treat, preform procedures or surgery on my pet named above upon my given consent. I also

authorize FPC's staff to handle my pet(s) and assist with treatment as directed by the doctor on duty. I understand FPC does not offer payment plans. I understand that I am

financially responsible and required to pay the total amount due at the time services are rendered. I am the owner or authorized agent of the said pet(s) listed above.

The information I provided above is accurate to the best of my knowledge

(Print) _____ (Sign) _____ (Date) _____