Kirksville Small Animal Hospital

New Client Information

Client Information

Owners Name:_____Co-Owner:_____Date:_____

Address*:*_____

Home Phone:_____Cell Number:_____Work Number:_____

Email Address:_____

We will be updating our reminder system in the future. Do you prefer: *Text *Phone *Email *Mail

Pet Information

Pet's Name:_____Color:_____*Dog *Cat *Other

Sex: *Male *Female Age:_____Birthdate:_____Breed:_____

Neutered/Spayed: *Yes *No At what age:_____

List Pets Current Medication_____

Reason For Today's Visit:_____***VACCINATIONS**

Please Circle Symptoms or Problems You Have Noticed With Your Pet

*Appetite Loss *Gagging *Sneezing *Behavioral Changes *Coughing *Thirst *Limping

*Gums Bleeding *Breathing Problems *Diarrhea *Loss of Balance *Vomiting *Worms

*Depression *Scooting *Weakness *Scratching *Increased Urination *Shaking Head

*Lethargic *Constipation *Eye Disorder

Pet's History (*circle all that your pet has received within the past year*):

*Feline Leukemia Test *Feline Leukemia Vaccine *Feline Distemper *Rabies

*Heartworm Test(dog) *Kennel Cough Vaccine *Distemper/Parvo (dog) *Dental

*Other_____*Prior Illness/Surgery:_____

Authorization: *I hereby authorize the veterinarian to examine, prescribe for and treat the above described pet.*

I assume responsibility for all charges incurred in the care of this pet. I also understand that

ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Payment Method: *Credit/Debit Card *Cash **Care Credit*

No longer accepting checks

Signature of client responsible for pet:_____