

WELCOME TO OUR PRACTICE

Client (owner) Information

Date: _____ Driver's License #: _____ Birthdate: _____

Name (Last Name First): _____ Spouse: _____

Address: _____ City, State, Zip: _____

Home Phone: (____) _____ Cell: (____) _____ Best place to reach you? _____

Work Phone: (____) _____ Employer: _____

Email Address: _____

Emergency Contact Name: _____ Phone: (____) _____

Number of pets in household (please specify type): _____

How did you hear about us? Please mark all that apply. Thank you.

- Friend or family (who may we thank?) _____ Local Shelter Family Coupons
 New Resident Ad Wellness Flyer Email Ad Referral Card Internet Search Billboard
 Walk/Drive By Phone Book Community Event _____ Other _____

Pet Information

Pet's Name: _____ Dog Cat Other _____

Sex: M F Age: _____ Birthdate: _____ Breed: _____

Color: _____ Neutered/Spayed: Yes No At what age?: _____

What age was pet obtained?: _____ Microchip? Yes No Microchip #: _____

Obtained From: Friend Breeder Pet Shop Humane Society Other _____

Obtained pet for (check all that apply): Companion Protection Breeding Show Other _____

Describe your pet's diet: _____

List your pet's current medications: _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Gagging | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Behavioral Changes | <input type="checkbox"/> Thirst | <input type="checkbox"/> Scratching |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Limping | <input type="checkbox"/> Urination Changes |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Scooting | <input type="checkbox"/> Weakness | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Shaking Head | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Eye Disorders: _____ | | |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Distemper | <input type="checkbox"/> Feline Leukemia Test | <input type="checkbox"/> Prior Surgery _____ |
| <input type="checkbox"/> Parvovirus (Dog) | <input type="checkbox"/> FVRCP (Infectious Disease – Cat) | <input type="checkbox"/> Prior Illness _____ |
| <input type="checkbox"/> Rabies (Dog/Cat) | <input type="checkbox"/> Dental | <input type="checkbox"/> Other: _____ |

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 the animal. I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Signature of client responsible for pet(s) _____ Date: _____

We look forward to having you as a part of our family here at Haven Animal Hospital! To improve your experience with us, we ask that you fill out the following information below and *e-mail it back to our practice* so we can promptly get you and your pet in to see the veterinarian!

Previous Veterinary Office Name:

Previous Vet Phone Number:

First & Last Name that your pet is under at previous clinic:

Any additional information you think we may need:

*** If your pet has been to multiple veterinary offices, please fill out the additional lines below.**

Previous Veterinary Office Name:

Previous Vet Phone Number:

First & Last Name that your pet is under at previous clinic:

Any additional information you think we may need:

Previous Veterinary Office Name:

Previous Vet Phone Number:

First & Last Name that your pet is under at previous clinic:

Any additional information you think we may need:

Previous Veterinary Office Name:

Previous Vet Phone Number:

First & Last Name that your pet is under at previous clinic:

Any additional information you think we may need:

Haven Animal Hospital – 1045 Fulton St. Grand Haven, MI 49417

Phone: 616.847.7387 – Fax: 844.387.6762 –

E-mail: havenanimal@havenanimalhospital.com