



8626 Roosevelt Way NE; Seattle, WA 98115 (206) 524-2020

Patient/Client Information

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

Owner's Name: _____ Cell#: (____) _____ - _____

Spouse/Other: _____ Cell#: (____) _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Alternate/Home Phone #: (____) _____ - _____

Employer's Name/Work Phone _____ #(____) _____ - _____

Preferred Phone number to reach you is (please circle one): Cell / Home / Work

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.**

Name of Previous/Current Veterinarian & phone number (if known):

How did you hear of our hospital?

- () Individual, Someone We May Thank? _____
() Yellow Pages, or another telephone directory?
() Hospital Sign/Drive By?
() Yelp or Facebook? _____
() Website? If so, which one? _____
() Other, please state: _____

DUE TO STATE LAW AND INSURANCE REQUIREMENTS, ALL DOGS & CATS MUST BE CURRENT ON RABIES VACCINATION.

Vaccination can be updated at the time of your appointment if it is not current.

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 reverse side and additional pets I present. 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 efforts become necessary. I understand that a service fee of \$30.00 will be assessed for each non-sufficient fund check and/or certified letter that must be sent. I understand that veterinary service is provided during nighttime hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided.

Signature _____ Date _____

Animal Medical History

Please complete information for all your pets - Thank You!	Pet #1	Pet #2	Pet #3
Pet's Name			
Species (Dog, Cat, Bird, etc.)			
Breed			
Description (Color and Markings)			
Age or Date of Birth (Approximate)			
Sex	Male / Female	Male / Female	Male / Female
Neutered or Spayed?	Yes / No	Yes / No	Yes / No
Indoors only or Indoor/Outdoor?			
Diet (Name of Your Pet's Food)			
Daily Medications, Vitamins or Treats			
Shampoo/Flea Products Used			
Microchipped? If yes, number?	Yes/No	Yes/No	Yes/No
Any chronic/reoccurring medical issues?			
Vaccinations	<i>Please note the dates the following vaccines/tests were given</i>		
	Pet #1	Pet #2	Pet #3
DOGS: DHLPPC (Distemper/Parvo)			
Bordetella (Kennel Cough)			
Rabies			
Other Vaccines - Please Specify			
CATS: FVRCP (Infectious Diseases)			
FELV (Feline Leukemia)			
Rabies			
Other Vaccines - Please Specify			
Heartworm Test (Dogs)			
FELV Test or FIV Test ? (Cats)			
Fecal Test (Stool Exam for Worms)			
Dentistry (Approx Date Work was Done)			
Geriatric Health Screen (Approximate)			