

Animal Hospital of New Bern

(252)649-1520 (252)649-1518 fax

Client information:

Date: _____

Owner's name _____ Co-Owner _____

Address _____

City _____ ZipCode _____

Home Phone _____ Cell _____

Work Phone _____ Co-Owners Phone _____

Email Address _____

How did you find out about our hospital? _____

Pet Information: Name _____ Type of pet _____

Breed _____ Color _____ Sex _____

Spayed/ Neutered (Y/N) _____ Age/ Date of Birth _____

Microchip number _____

Where did you acquire your pet? _____

Location & date of last exam: _____

Location & date of last vaccines: _____

Recent lab work (please attach) _____

Does your pet take monthly heartworm, flea, or tick prevention? If so, what type? How often?

When did you last administer heartworm prevention? _____ Flea/tick prevention? _____

Other medications: _____

What kind of food does your pet eat? _____

(Brands, dry, wet, raw, table food...)

Pre-existing medical or behavioral concerns (i.e. inappropriate urination, defecation, biting...)

Recent Medical Records:

If you have your pet's medical records, please attach them to this form.

Who may we contact for medical records? _____

Previous Veterinarian's name and phone number _____

Treatment Authorization:

I hereby authorize the veterinarian to examine and treat the pet described above. I assume responsibility for all charges. I also understand that payment is due at the time of release, and that a deposit may be required prior to treatment.

Owner's Signature _____ Date _____