Animal Hospital of New Bern

(252)649-1520 Fax (252)649-1518

Animalhospitalofnewbern@gmail.com

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, defection, 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_____