

# Lone Mountain Animal Hospital

For Office Use

## New Client Information

Date \_\_\_\_\_

### Personal Information

Owner's Name (first, last) \_\_\_\_\_

Spouse/Other \_\_\_\_\_

Street Address \_\_\_\_\_ Unit/Apt. \_\_\_\_\_

City, State, Zip+4 \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

In case of emergency, please call \_\_\_\_\_ at telephone number \_\_\_\_\_

### How did you hear about our hospital?

Hospital Sign \_\_\_\_\_ Yellow Pages \_\_\_\_\_ American Animal Hospital Association \_\_\_\_\_

Animal Foundation \_\_\_\_\_ NSPCA \_\_\_\_\_ Internet \_\_\_\_\_ Facebook \_\_\_\_\_

Individual - someone we may thank: \_\_\_\_\_ Other - please specify: \_\_\_\_\_

### Previous animal hospital/veterinarian information

Name of clinic or doctor: \_\_\_\_\_

City/State: \_\_\_\_\_

May we request your pet's health records?      Yes    No

Any other information you feel we should know about your pet?

---

---

Do you wish to receive our free e-mail monthly newsletter for seasonal care tips and current health topics?

Yes - E-mail Address: \_\_\_\_\_ No

### **ALL FEES ARE DUE AT THE TIME THE PATIENT IS RELEASED**

Upon your request, we will be happy to provide you with a written estimate of fees for any treatment, emergency care, surgery, or hospitalization. A deposit prior to treatment may be required depending upon the amount of the estimate.

Signature of Owner \_\_\_\_\_

**Animal Medical History** (complete one column for each pet, as completely as possible)

<b>Pet Information</b>	<b>1st Pet</b>	<b>2nd Pet</b>	<b>3rd Pet</b>
Name:			
Species (dog, cat, reptile, bird, etc.):			
Breed:			
Description/Color(s):			
Date of Birth:			
Circle Sex: (F, M, Female/Spayed, Male/Neutered)	<input type="checkbox"/> F <input type="checkbox"/> F/S <input type="checkbox"/> M <input type="checkbox"/> M/N	<input type="checkbox"/> F <input type="checkbox"/> F/S <input type="checkbox"/> M <input type="checkbox"/> M/N	<input type="checkbox"/> F <input type="checkbox"/> F/S <input type="checkbox"/> M <input type="checkbox"/> M/N
Length of time owned:			
Diet (type of pet food):			

**Vaccination History - Please give dates of most recent vaccinations:**

<b>DOGS</b>	<b>Pet 1</b>	<b>Pet 2</b>	<b>Pet 3</b>
Distemper			
Rabies			
Parvo Virus			
Bordatella (kennel cough)			
Lyme			

<b>CATS</b>	<b>Pet 1</b>	<b>Pet 2</b>	<b>Pet 3</b>
Feline Distemper			
Rabies			
Feline Leukemia			

**Previous Medical History** (indicate pet's name if you have more than one pet above)

Current special diet?

Currently on medication? Type?

Prior illness?

Prior surgery?

Prior urinary problem?