Anacapa Animal Hospital

NEW PATIENT MEDICAL FORM

So that we may better serve you and your pets, please complet this form as fully as possible for our medical records.

Owner/Agent ___________________________

Address ________________________________

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Home Phone (   )________________________

Work Phone (   )________________________

email address ___________________________

Occupation______________________________

Co-Owner (Spouse)_______________________

Home Phone (   )________________________

Work Phone (   )________________________

Occupation______________________________

Referred by______________________________

Previous Veterinarian: ____________________

Pet's Name ______________________________

Birthdate ______________________________

Species ❒ Dog ❒ Cat ❒ Rabbit ❒ Bird

Other (Species) __________________________

Breed ______________________________

Color ______________________________

Sex ❒ Male ❒ Female ❒ Neutered ❒ Spayed

Obtained From: ❒Pet Store ❒Breeder

❒ Humane Society ❒ Other__________________

You have your pet primarily for: ❒ Show ❒ Breeding

❒ Companionship ❒ Work ❒ Other_________

Number of Pets in Household: Dogs____ Cats___

Other______________________________________

Vaccine History (if known, date of last vaccination)

Canine: DA2P(Distemper): _____________

Parvo: ________

Rabies: ________________

Feline: FVRCP: ________________

Rabies: ________________

FeLV: ________________

Your Pet is: ❒ Indoors/Outdoors ❒ Only Indoors ❒ Only Outdoors

When outdoors your pet is: ❒ Loose

❒ Leashed ❒ Fenced ❒ Other____________

Your Pet's usual diet is: ________________________

I, the undersigned, assume financial responsibility for all charges incurred, and agree to pay all such charges at the time services are rendered or as arranged prior to examination and/or treatment.

Drives Lic#: ______________________ Exp.: ________________ SS#: ______________________

Owner/Agent Signature _______________________________________ Date ______________________

Owner/Agent Printed Name______________________________________