SMALL ANIMAL MEDICINE

JOE METCALF, D.V.M.
CHRIS PEEK, D.V.M.

6001 DAVIS BOULEVARD
N. RICHLAND HILLS, TEX. 76180

CLINIC: 485-2450

PATIENT AND CLIENT INFORMATION SHEET

Thank you for giving Davis Blvd. Animal Clinic the opportunity to care for your pet. So that we may become better acquainted, please complete the following:

MR.
MRS. OWNER(S) ______________ LAST FIRST INITIAL SPOUSE'S ______________ LAST FIRST INITIAL
DR.
MS.

CHILDREN ______________ FIRST NAMES ______________

ADDRESS ______________ CITY STATE ZIP CODE

RESIDENCE PHONE __________ WORK PHONE __________ SPOUSE'S WORK PHONE __________

PLACE OF EMPLOYMENT __________ EMPLOYER / __________ TITLE ADDRESS __________

SPOUSE'S PLACE OF EMPLOYMENT __________ EMPLOYER / __________ TITLE ADDRESS __________

IF NECESSARY, MAY WE CALL YOU AT WORK? ☐ YES ☐ NO

HOW DID YOU BECOME AWARE OF OUR HOSPITAL?
☐ YELLOW PAGES ☐ HOSPITAL SIGN ☐ OTHER
☐ PERSONAL RECOMMENDATION - WHO MAY WE THANK? __________ NAME

So that we are able to suit your individual needs - which do you feel most applies to you:

Check One.
(1) ☐ I feel that my pet is another member of our family.
(2) ☐ I feel that my pet is just a pet.

Check One.
(1) ☐ I want the best medical care available for my pet; please recommend anything that you feel is necessary for good health.
(2) ☐ I want good medical care for my pet, but there is a limit to what I am able to have done.
(3) ☐ I want you to perform only the services that I request.

Check One.
(1) ☐ I want to learn as much as I can about pet health care, please explain in detail what has been done for my pet or what is needed.
(2) ☐ I would prefer you just summarize what has been done for my pet or what is needed.
(3) ☐ I want my pet healthy, but don't need to know what has been done.

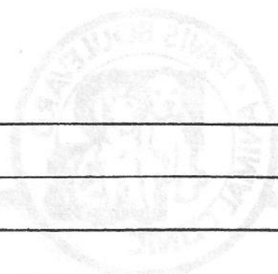
Check One.
(1) ☐ I prefer to be present when my pet is examined and treated.
(2) ☐ I would rather not see my pet examined and treated.

I GIVE DAVIS BLVD ANIMAL CLINIC PERMISSION TO RELEASE RECORDS IF THE NEED ARISES
→

WOULD YOU LIKE US TO KEEP YOU INFORMED ABOUT PROCEDURES TO LENGTHEN YOUR PETS LIFE? ☐ YES ☐ NO

int. __________

(over)



How old was your pet when you acquired it? ____________
How many hours is your pet outside each day? ____________
What is the best time to reach you at home? ____________
What prior illness or surgery should we know about? ____

____

____

All fees are due upon release of patient. Please indicate your choice of payment.

☐ Cash ☐ Check (Drivers License required) ☐ MC/VISA

PET INFORMATION (Please fill in the following for each pet.)

	PET 1	PET 2	PET 3
NAME			
SPECIES Cat,Dog,Other			
BREED			
DESCRIPTION			
DATE OF BIRTH			
SEX			
ALTERED			
DATES VACCINATED			
DHLP (Dog)			
PARVOVIRUS (Dog)			
FVRCP (Cat)			
RABIES (Both)			
HEARTWORM TEST			
FECAL CHECK (Worms)			
DENTISTRY			
FELEUK TEST (Cat)			
FELEUK VACCINE			
ON PROBAN?			
ON HEARTWORM PREV.?			
DIET?			

Are any of the following a concern to you in your's pet behavior? Please Check.

☐ Excessive Barking ☐ Biting ☐ Shedding ☐ Straying from Home ☐ House Breaking ☐ Smell
☐ Problem Around Children ☐ Excessive Itching/Scratching ☐ Wetting/Spraying In House
☐ Overly Rambunctious/Overly Enthusiastic

Would you be interested in learning how to improve your pet's manners? Yes ☐ No ☐

Is your pet currently on a special diet or medication? ____________________

What health care or grooming products are you currently using? ____________________

List any known drug allergies. ____________________

How long would you like your pet to live? ____________________

____
CLIENT'S SIGNATURE

Again, thank you for giving us the opportunity to serve you.

Davis Blvd. Animal Clinic
6001 Davis Blvd.
North Richland Hills, Texas 76180
(817) 485-2450

Davis Blvd. Animal Clinic Financial Policy

Thank you for choosing us as your veterinary pet care provider. We are committed to the treatment and health education of your pet. Please understand that payment of your bill is to be considered part of the treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

Full payment is due at time of services. We accept cash, checks, Visa, MasterCard, and Discover.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the financial policy. I understand and agree to this financial policy.

X_________________________________ Date________________

Signature of the responsible party