Scott Weeks, D.V.M.

"Complete care under one very qualified roof!"

Client Information

Thank you for giving our Doctors and Staff the opportunity to care for your pet. So that we may become better acquainted, please complete all of the following:

Date: ____________________

(please print)

Mr. Mrs. Dr. Ms. first ______ last ______ driver's license ______ required if paying by check

Mr. Mrs. Dr. Ms. first ______ last ______ driver's license ______ required if paying by check

Address: ______ Email address: ______

City: ______ State ______ Zip ______

OK to text cell phone?

Home phone ______ Work phone ______ ext. ______ Cell phone ______ yes ❐ no ❐

Co-owner or Spouse ______ Work phone ______ ext. ______ Cell phone ______ yes ❐ no ❐

How did you become aware of our hospital? Personal Recommendation (who may we thank?) ____________________

Yellow Pages Internet Sign on Hospital Newspaper Coupon Veterinary Referral (Name of Dr. or Hospital) ____________

Patient Information

Pet's name: ______ Sex: M ❐ F ❐ Neutered? yes ❐ no ❐

Species: Dog Cat Other: ______

Breed: ______

Date of Birth (estimate if necessary): ______

Color: ______

Microchip Identification? Yes ❐ No ❐

Canine **Previous Vaccination Dates** **Feline**

enter dates below

Canine		Feline
Rabies		Rabies
DHLP		FVRCPC
Parvo/Corona		Leukemia
Kennel Cough		FIP
Lyme Disease		FIV
Fecal Exam		Fecal Exam
Heartworm Test		

Is this pet on heartworm prevention? yes ❐ no ❐

Is this pet on monthly flea control? yes ❐ no ❐

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All fees are due when services are rendered or upon release of patient. We accept cash, check, MC/VISA, AMEX, and Discover.

Signature: ______________________________