

Patient Check-In Form

Pet Owner's Name _____ Date: _____

Pet Name _____ Email: _____

List any changes in address or phone _____

Does your pet need: (please circle one, price varies, please ask receptionist)

Toe Nail Trim	Yes	No
Ear Cleaning	Yes	No
Anal Gland Expression	Yes	No
Microchip	Yes	No
Dental Cleaning	Yes	No

Method of payment for TODAY's services: Cash Debit Visa Master Card Care Credit
 (No checks, Discover or American Express)

Are you familiar with Care Credit? (3 months no interest credit plan)	Yes	No
Would you like information on Care Credit?	Yes	No
Would you like information on Pet Insurance?	Yes	No

Is your Pet (please circle)					
1. Eating Normal	Yes	No	13. Eye problems	Yes	No
2. Drinking Normal	Yes	No	14. Ear problems	Yes	No
3. Eating Excessively	Yes	No	15. Skin problems	Yes	No
4. Drinking Excessively	Yes	No	16. Teeth/gum problems	Yes	No
5. Coughing	Yes	No	17. Bad breath	Yes	No
6. Sneezing	Yes	No	18. Hair loss / shedding	Yes	No
7. Vomiting (How often?)	Yes	No	19. Scratching / itching (Scale 1-10, 10 being the worse)	Yes	No
8. Diarrhea (How often?)	Yes	No	20. Fleas	Yes	No
9. Lethargic	Yes	No	21. Ticks	Yes	No
10. Urination problem	Yes	No	22. Lump or bumps	Yes	No
11. Scooting	Yes	No	23. Other (explain)		
12. Limping (which leg?)	Yes	No	24. Other (explain)		

Please list any additional information: _____

Is your pet experiencing any of the following behavior issues: (please circle)

a) Vocalizing	Yes	No	c) Aggressive	Yes	No
b) Destroying property / chewing	Yes	No	d) Scared of thunderstorm	Yes	No

What prevention is your pet on?

Heartworm prevention	Yes	No
Flea prevention	Yes	No
Do you need refills on Heartworm or Flea prevention?	Yes	No