

PATIENT REGISTRATION AND MEDICAL HISTORY FORM

*NEW PRAIRIE SMALL ANIMAL CLINC
5424 E US 20
Rolling Prairie, IN 46371*

Owner's Name _____

Address _____

Home Phone Number _____ City _____ State _____ Zip _____
Work _____

E-Mail Address _____

How did you hear about us? _____

Social Security Number _____ Driver's License Number _____

Place of Employment _____

Patients Name _____ Breed _____

Pet's Date of Birth _____ Sex: Male Female

Color _____ Altered: Yes No

Dog Cat Other Microchip Yes No

Approximate Date (month/year) of last: _____ Number _____

Distemper Vaccination _____ Fecal Examination _____

Rabies Vaccination _____ Heartworm Examination _____

Is your pet allergic to any foods or drugs? Yes No

If yes, specify _____

Briefly list prior diseases, surgical procedures, injuries: _____

Current Medications: _____

To allow for continuity in the medical care of your pet, please list the name, city, and state of the most recent veterinary hospital(s) at which your pet was examined/treated.

Veterinary Clinic _____ Address _____

Professional fees are to be paid at the time services are rendered. We have no provision for the extension of credit or billing. We require a copy of a Driver's License for all New Clients. Overdue payments will be subject to a 2% monthly interest fee.

Signature of Owner or Owner's Agent _____