



NEW PATIENT FORM

Welcome to Four Paws Animal Hospital & Wellness Center. Thank you for giving us the opportunity to care for your pet. Please help us meet your needs better by taking a moment to complete this information sheet.

PET NAME	<input type="checkbox"/> Other _____	<input type="checkbox"/> DOG	<input type="checkbox"/> CAT
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BREED	COLORS
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<input type="checkbox"/> MALE	<input type="checkbox"/> MALE-NEUTERED	<input type="checkbox"/> FEMALE	<input type="checkbox"/> FEMALE-SPAYED
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PET DATE OF BIRTH <i>(or approximate age if unknown)</i>	MICROCHIP NUMBER
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IS THERE ANYTHING SPECIAL THAT WE SHOULD KNOW ABOUT YOUR PET? <i>(For instance, doesn't like feet touched, is afraid of men, may bite, etc.)</i>

DID YOU BRING PAST MEDICAL RECORDS?	Y N
DID YOU BRING RECENT VACCINE RECORDS?	Y N
WHAT ANIMAL HOSPITAL SHOULD WE CONTACT FOR THESE RECORDS?	

ANY PAST MEDICAL CONDITIONS OR SURGERIES THAT WE SHOULD KNOW ABOUT YOUR PET?
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IS YOUR PET ON ANY MEDICATIONS? IF YES, PLEASE LIST THE NAMES & DOSAGES BELOW

 Signature Date