



W E L C O M E



Thank you for giving us the opportunity to care for your pet. To help us provide the highest level of care, please take a few moments to fill out the information below as accurately as possible.

CLIENT INFORMATION

Name: _____ Spouse's Name: _____

Address: _____

Street

PO Box

City

State

Zip Code

Home #: _____ Email Address: _____

Work #: _____ Spouse's Work #: _____

Cell #: _____ Spouse's Cell #: _____

The best way to contact me is by calling my: Home # Work # Cell #

Children's Names & Ages: _____

How did you hear about the Wellington Veterinary Clinic?

Yellow Pages

Sign

Doctor Referral

Recommendation

If a recommendation, whom may we thank? _____

PATIENT INFORMATION

Name: _____ Species: Canine Feline

DOB: _____ Gender: Male Female

Breed: _____ Is your pet spayed or neutered? _____

MEDICAL HISTORY

-please list the date and veterinary practice where each vaccine was last given-

Canine

Rabies: _____ DA2PPV (Canine Distemper): _____

Giardia: _____ Heartworm Test/Prevention: _____

Bordetella: _____ Other: _____

Feline

Rabies: _____ FVRCCP (Feline Distemper): _____

FeLV (Feline Leukemia): _____ Other: _____

Please list any additional medical or surgical information that we should be made aware of: _____

MEDICAL AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe, and treat the above described animal. I assume responsibilities for all charges incurred by the care of my pet, and understand that these charges will be paid in full at the time services are rendered. I also understand a deposit may be required for any surgical treatment.

Signature of Owner: _____ Date: _____