

**HICKORY VETERINARY HOSPITAL  
NEW CLIENT INFORMATION**

Thank you for giving us this opportunity to care for your pet. Please help us meet your needs better by completing both sides of this information sheet. Items in bold italics are required.

*Last Name:* \_\_\_\_\_ *First Name:* \_\_\_\_\_.

*Spouse/Other: Last:* \_\_\_\_\_ *First Name:* \_\_\_\_\_.

*Address:* \_\_\_\_\_  
\_\_\_\_\_.

*City:* \_\_\_\_\_ *State:* \_\_\_\_\_ *Zip:* \_\_\_\_\_.

*Home Telephone:* (\_\_\_\_) \_\_\_\_\_ *Work Telephone:* (\_\_\_\_) \_\_\_\_\_ *Spouse Work Number:* (\_\_\_\_) \_\_\_\_\_.

*Cell phone:*(\_\_\_\_) \_\_\_\_\_ *Fax Number:* (\_\_\_\_) \_\_\_\_\_.

*E-mail address:* \_\_\_\_\_

*In case of EMERGENCY, please call* \_\_\_\_\_ *at* (\_\_\_\_) \_\_\_\_\_.

**How did you hear of our hospital?**

\_\_\_ Individual; someone we may thank: \_\_\_\_\_ Yellow Pages \_\_\_.

Hospital sign \_\_\_ Other: \_\_\_\_\_.

Referral Veterinarian/Name: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_.

**PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. If you pay by check or credit card, please complete the following:**

Credit Card Number: \_\_\_\_\_ Credit Card Type: \_\_\_\_\_.

**Driver's License Information:** State Issued: \_\_\_\_\_ License Number: \_\_\_\_\_.

**Spouse's Driver's License:** State Issued: \_\_\_\_\_ License Number: \_\_\_\_\_.

SSN: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_.

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_.

Spouse's Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_.

Credit Card Expiration date: \_\_\_\_\_.

Employer's Address: \_\_\_\_\_.

Pharmacy Name: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_.

Referral Doctor Fax:(\_\_\_\_) \_\_\_\_\_ Referral Doctor Hospital: \_\_\_\_\_.

Referral Doctor Phone:(\_\_\_\_) \_\_\_\_\_.

Spouse's Employer's Address: \_\_\_\_\_.

**What time & what telephone number is it best to reach you about your pet?**

Time: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_.

To prevent the spread of infectious diseases and parasites hospitalized and boarded animals must be current on all vaccines and free of internal and external parasites. In the event that I cannot provide written proof of such vaccines, I authorize the doctor to provide vaccines and parasite control as needed for my pet.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_.

**Please Turn Over and Complete the Rest of this form!**

**NEW CLIENT INFORMATION (Continued)**

**ANIMAL MEDICAL HISTORY**

*Pet's Name:* \_\_\_\_\_.

**Please check all that apply:** Addison's Disease \_\_\_ Aggressive with other pets \_\_\_ Allergic reaction to vaccines \_\_\_.  
Allergic to bee stings \_\_\_ Allergic to Ketamine \_\_\_ Antibiotic sensitive \_\_\_ Asthma \_\_\_ Animal bites \_\_\_ Diabetic \_\_\_.  
Grand Mal Seizures \_\_\_ Nervous at the vet \_\_\_ Seizures \_\_\_ Vaccine reaction \_\_\_.

*Maturity (circle one): Juvenile/Adult/Geriatric*

*Species (cat,dog,other):* \_\_\_\_\_ *Breed:* \_\_\_\_\_ *Sex:* \_\_\_\_\_ *Spayed/Neutered?: (check one) Yes \_\_\_ No \_\_\_.*

*Description (color):* \_\_\_\_\_ *Birth Date:* \_\_\_\_\_ *Age (years):* \_\_\_\_\_.

*Weight:* \_\_\_\_\_ *Doctor Preference:* \_\_\_\_\_ *Rabies Tag#:* \_\_\_\_\_.

*Additional Information:* \_\_\_\_\_.

*Special Instructions:* \_\_\_\_\_.

*Heartworm Preventative - Brand Name:* \_\_\_\_\_ *Last Date Given:* \_\_\_\_\_.

*Chronic Ailment? \_\_\_ If Yes, please describe:* \_\_\_\_\_.

*Is your pet on any medications? If so, please list them:* \_\_\_\_\_.

*Is your pet on a special diet? Please describe:* \_\_\_\_\_.

*Do you breed your animal? \_\_\_ Tattoo # (if applicable):* \_\_\_\_\_ *AVID Chip #* \_\_\_\_\_.

*Next flea treatment due:* \_\_\_\_\_ *Flea medicine used:* \_\_\_\_\_.

*Heartworm Preventative due:* \_\_\_\_\_ *Licence #:* \_\_\_\_\_.

**VACCINATIONS : PLEASE GIVE DATES/RESULTS OF LAST VACCINES/TESTS and NAME OF VETERINARY HOSPITAL WHERE THEY WERE GIVEN**

*DHPP:* \_\_\_\_\_ *Fecal exam:* \_\_\_\_\_ *Feline Leukemia Test/Vaccine (cat):* \_\_\_\_\_.

*Parvovirus:* \_\_\_\_\_ *Rabies (dog/cat):* \_\_\_\_\_.

*DHLPP (distemper-dog):* \_\_\_\_\_ *FVRCP (infectious diseases-cat):* \_\_\_\_\_.

*Other vaccines (Bordetella, Lymes, Corona):* \_\_\_\_\_.

*Heartworm Tested:* \_\_\_\_\_.

**ILLNESSES/SURGERIES**

*Prior Illness:* \_\_\_\_\_.

*Prior Surgery:* \_\_\_\_\_.

**ALLERGIC REACTION TO MEDICATION/VACCINE? (Circle One) Yes / No Med / Vaccine**

*If Yes enter name of Med or Vaccine:* \_\_\_\_\_.

**PET ORIGIN (Check One):** \_\_\_ Humane Society \_\_\_ Pet Shop \_\_\_ Kennel \_\_\_ Stray \_\_\_ Friend  
\_\_\_ Advertisement \_\_\_ Individual (nonbreeder)

**HOW LONG HAVE YOU OWNED YOUR PET?:** \_\_\_\_\_.

**OTHER PETS:** Dog(s): \_\_\_\_\_ How many?: \_\_\_\_\_.

Cat(s): \_\_\_\_\_ How many?: \_\_\_\_\_.

Other(s): \_\_\_\_\_ How many?: \_\_\_\_\_.