



## PATIENT & CLIENT INFORMATION

Thank you for giving CAC the opportunity to care for your pet.  
So that we may become better acquainted, please complete the following:

Owner: \_\_\_\_\_ Spouse: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Spouse Work: \_\_\_\_\_  
Email: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Spouse's Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How did you become aware of our clinic? \_\_\_\_\_ Other Clinic/Hospital \_\_\_\_\_  Website (specify): \_\_\_\_\_  
Personal recommendation by: \_\_\_\_\_ [\(ask about our Referral Program\)](#)  
 Drive-by  Kudzu.com  Yellow Pages  Other (specify): \_\_\_\_\_

Payment for services is required at the time they are rendered. Business/personal checks are NOT accepted. We accept Cash, Debit, MasterCard, Visa, American Express, and Discover

So that we will be best able to suit your individual needs, please check the statement that you feel most accurately applies to you.

- I consider my pet a member of the family and I want the best medical care available.
- I want good medical care for my pet, but there is a limit to what I am able to have done
- I want you to perform only the services that are absolutely necessary.

## PET HISTORY

Name: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_  
Birthday: \_\_\_\_\_ Sex:  Male  Neutered  Female  Spayed Color: \_\_\_\_\_  
Microchip Number: \_\_\_\_\_ Tattoos/Markings: \_\_\_\_\_  
Previous Veterinary Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_  
Chronic Illnesses: \_\_\_\_\_  
Previous Illnesses: \_\_\_\_\_ Previous Surgeries: \_\_\_\_\_  
Known Allergies to:  Drugs: \_\_\_\_\_  Food: \_\_\_\_\_  
 Vaccines: \_\_\_\_\_  Other: \_\_\_\_\_  
Is your pet on heartworm prevention?  No  Yes- What kind? \_\_\_\_\_ Last date given? \_\_\_\_\_  
Is your pet on Flea/Tick prevention?  No  Yes- What kind? \_\_\_\_\_ Last date given? \_\_\_\_\_  
Currently on medication?  No  Yes- Please specify: \_\_\_\_\_  
Type and amount of food: \_\_\_\_\_ Table scraps:  Yes  No  
Origin of Pet:  Pet Store  Kennel  Humane Society  Breeder  Friend  Other: \_\_\_\_\_  
Afraid of Storms:  Yes  No Are there any other pets in your home?  No  Yes- What kind? \_\_\_\_\_  
Reason for today's visit: \_\_\_\_\_

I grant a model release to Chattahoochee Animal Clinic to use images of my pet and myself in CAC literature and advertising.  
I understand that there is not compensation for this release. \_\_\_\_\_ (initials)

I hereby grant authority to the Veterinarian or Veterinarians in charge of the care of the pet describe above to administer and treatment, or to administer such anesthetics and to perform such operations as deem necessary or advisable in the diagnosis and treatment of this pet. I also understand that an animal hospitalized will be requires to have current vaccinations and will be vaccinated prior to admission if not current.

Signature of Owner or Authorized agent: \_\_\_\_\_ Date: \_\_\_\_\_