New Client/ New Patient Form

Please fill out and return to the Front Desk.

Middletown Animal Hospital
3615 Grand Avenue
Middletown, OH 45044
(513) 422-0615

Todays Date: [_____]

Pet Owner Information (Financially Responsible Party)

First and Last Name_____

Spouse's Name_____

Address_____

City, State_____ Zip_____

Primary Phone_____□Cell □Home

Secondary Phone_____ □Cell □Home

Spouse Primary Phone_____□Cell □Home

Employer Name_____

Employer Number_____

Preferred Method of Contact_____

Email Address_____
* your email address will not be sold.

1.) I am giving Middletown Animal Hospital the authority to take and use my pet's pictures on their Website, Social Media, and Slideshow.
YES **NO**

2.) I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that prior to treatment, a full explanation of the procedure(s) involved will be given by the veterinarian and/or staff in the care of my animal(s). I agree to pay for all services rendered by this office. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in this office. We will not use your information for marketing communications without your written authorization. I consent to the use of periodic appointment reminder phone calls, voice mail messages, postcards, email or letters.

Signature_____**Date**_____

Pet Information

Name_____

Birthdate/Age_____

Dog Cat Other_____

Breed_____

Coat Color/Markings_____

Sex: Male Female **Altered**: Spayed/Neutered

What are we seeing your pet for today?
_____

Is there anything you would like to bring up to the vet's attention?
_____

Would you like any of these services?
Nails: YES or NO
Anal Gland Expression: YES or NO

Do you need any refills on any medications?
_____

Please mark any symptoms you have noticed with your pet:

___ Appetite Loss
___ Behavioral Changes
___ Breathing Problems
___ Coughing
___ Depression
___ Diarrhea
___ Eye Problems
___ Thirst
___ Weakness
___ Hard Stool
___ Gagging
___ Gums Bleeding
___ Limping
___ Loss of Balance
___ Scratching
___ Shaking Head
___ Sneezing
___ Vomiting
___ Increased Urination
___ Decrease Urination

___ Other_____

___Other_____