



## CLIENT / PATIENT INFORMATION

**Owner**                      First: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last: \_\_\_\_\_

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Address: \_\_\_\_\_

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Home #: (    )                      Work #: (    )                      Cell #: (    )

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Email Address: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

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Employer: \_\_\_\_\_ Position: \_\_\_\_\_

**Spouse or Partner**                      First: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last: \_\_\_\_\_

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Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Emergency Contact**                      Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Your Cat (Patient)**                      Name: \_\_\_\_\_  Female  Male                      Date Altered: \_\_\_\_\_

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Birthdate (approx): \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_

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Indoor  Outdoor  Both      Declawed  Yes  No  Front  Back      Microchip  No  Yes      Number \_\_\_\_\_

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Diet: Canned \_\_\_\_\_ brand                      Dry \_\_\_\_\_ brand

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Leukemia (FeLV)  Not Tested  Positive  Negative                      Date Tested: \_\_\_\_\_

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FIV (AIDS)  Not Tested  Positive  Negative                      Date Tested: \_\_\_\_\_

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Last Vaccination Dates      FVRCP: \_\_\_\_\_ FeLV: \_\_\_\_\_ Rabies: \_\_\_\_\_ Other: \_\_\_\_\_

Abnormalities, previous problems, drug reactions/allergies: \_\_\_\_\_

**Your Other Cats**                      Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

**How Did You Find Us?**

Veterinarian  Friend  Drove By  Web Site  Yellow Pages – Please indicate the book if you recall:  Verizon Snohomish County

Who may we thank for referring us? \_\_\_\_\_  Qwest Seattle Metro

Optional: If applies, reason for changing veterinarian: \_\_\_\_\_  Verizon SnoKing/Seattle

\_\_\_\_\_  Qwest Greater Snohomish

\_\_\_\_\_  Others

**Financial Policy:**

Thank you for choosing us as your veterinary health care provider. We are committed to your cat's treatment being successful and as cost effective for you as possible. The following is a statement of our Financial Policy, which helps keep our costs down. We ask you to read it and sign below prior to exam or treatment.

Full payment is due at the time of services. We accept cash, check and most major credit cards.

A deposit of 50% of estimated charges may be required before extensive services are rendered.

Print Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_