

Yosemite Pet Hospital

Client Information Sheet

For Office Use Only:

Client ID _____

Title (circle):		Dr., Dr. & Dr., Miss, Mr., Mrs., Mr. & Mrs., Ms., Rev., Rev. & Mrs.	
Primary Owner	First Name	M	Last Name
	Street Address		
City	State, Zip		
Primary Phone	Circle one: Home / Cell / Pager / Work / Fax		
Other Phone	Circle one: Home / Cell / Pager / Work / Fax		
Email:			YPH will not share your Email address.
How would you prefer to be contacted for reminders and newsletters?			
		Email: <input type="checkbox"/>	Text message: <input type="checkbox"/> Mail: <input type="checkbox"/> Telephone: <input type="checkbox"/>
Primary Owner drivers license #	Exp.	State	Owners Date of Birth: (Required by DEA) Employer:
How did find Yosemite Pet Hosp.	Yellow Pages: <input type="checkbox"/> Yellow Pages Online: <input type="checkbox"/> Sign: <input type="checkbox"/> Internet: <input type="checkbox"/> Website: <input type="checkbox"/> Mailing: <input type="checkbox"/>		
Were you referred by someone?	If yes, who may we thank for the referral?		
Occasionally, our hospital shares cute patient images via social network sites. Please check the following opt out box if you would not like to have your patient included.		Opt Out <input type="checkbox"/>	
Spouse / Secondary owner	First Name	M	Last Name
	Spouse/Secondary owner primary phone		
		Circle one: Home / Cell / Pager / Work / Fax	
Secondary Owner drivers license #	Exp.	State	Employer:

Pet Information		For office use only: Patient ID: _____	
Patient name:		Previous Veterinarian?	Do you have records?
Species (Circle one) Dog CAT	Breed:	Sex: Female <input type="checkbox"/> Female Spayed <input type="checkbox"/> Male <input type="checkbox"/> Male Neutered <input type="checkbox"/>	
Date of Birth:		OR _____ Years and _____ Months	
Registration # (if any)		Microchip #	Color / Markings
Allergies / Chronic Medical conditions			
Deaf (circle one) Yes No	Blind (circle one) Yes No	Prescription Diet? (circle) Yes/No If yes, what type:	
Travels out of Area Yes No		Any vaccine reactions? (circle) Yes/No	
		If Yes, which vaccine?	What type of reaction?
Canine Information		Feline Information	
Is your dog around infants or children? Yes No		Declawed? Yes No If yes, 2 feet or 4 feet?	
Heartworm prevention? If Yes, what method? Yes No		Does your cat live with any FeIV/FIV positive cats? Yes No	
Exposed to groomers, kennels, dog parks, training classes? Yes No		Circle one: indoor, outdoor, both	
Exposed to rats or mice, wildlife or cattle? Yes No			

24 hr notice required for any cancellation of appointment

Failure to provide notice may result in a "No Show" fee being charged to your account.

Initials _____

Signature _____

Payment due at time of service.

We accept Cash, Personal Checks, Visa Mastercard.

Date _____

Additional Pet Information		For office use only: Patient ID: _____	
Patient name: _____		Previous Veterinarian? _____	Do you have records? _____
Species (Circle one) Dog CAT	Breed: _____	Sex: Female Female Spayed Male Male Neutered <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Date of Birth: _____		OR _____ Years and _____ Months	
Registration # (if any) _____		Microchip # _____	Color / Markings _____
Allergies / Chronic Medical conditions _____			
Deaf (circle one) Yes No	Blind (circle one) Yes No	Prescription Diet? (circle) Yes/No If yes, what type: _____	
Travels out of Area Yes No		Any vaccine reactions? (circle) Yes/No	
		If Yes, which vaccine? _____	What type of reaction? _____
Canine Information		Feline Information	
Is your dog around infants or children? Yes No		Declawed? Yes No If yes, 2 feet or 4 feet? _____	
Heartworm prevention? If yes, what method? Yes No		Does your cat live with any Felv/FIV positive cats? Yes No	
Exposed to groomers, kennels, dog parks, training classes? Yes No		Circle one: indoor, outdoor, both	
Exposed to rats or mice, wildlife or cattle? Yes No			

Additional Pet Information		For office use only: Patient ID: _____	
Patient name: _____		Previous Veterinarian? _____	Do you have records? _____
Species (Circle one) Dog CAT	Breed: _____	Sex: Female Female Spayed Male Male Neutered <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Date of Birth: _____		OR _____ Years and _____ Months	
Registration # (if any) _____		Microchip # _____	Color / Markings _____
Allergies / Chronic Medical conditions _____			
Deaf (circle one) Yes No	Blind (circle one) Yes No	Prescription Diet? (circle) Yes/No If yes, what type: _____	
Travels out of Area Yes No		Any vaccine reactions? (circle) Yes/No	
		If Yes, which vaccine? _____	What type of reaction? _____
Canine Information		Feline Information	
Is your dog around infants or children? Yes No		Declawed? Yes No 2-feet or all 4 feet? _____	
Heartworm prevention? If yes, what method? Yes No		Does your cat live with any Felv/FIV positive cats? Yes No	
Exposed to groomers, kennels, dog parks, training classes? Yes No		Circle one: indoor, outdoor, both	
Exposed to rats or mice, wildlife or cattle? Yes No			

X _____
Signature

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Date