

Yosemite Pet Hospital

Client Information Sheet Rev 03.10

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?		
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 _____

X _____
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 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			

X _____
Signature

Payment due at time of service.
We accept Cash, Personal Checks, Visa Mastercard.

_____ Date