

**TRUESDELL**  
Animal Care Hospital and Clinic

**Client Information:**

Owner's Name:

Spouse/Co-Owner:

Email:

Email:

Employer Name:

Employer Name:

Birthdate:

Mailing Address:

Home Phone:

Cell Phone:

City/State/Zip:

Work Phone:

**Emergency Contact:**

Contact Name:

Phone Number:

**Pet Information:**

Pet's Name:

Pet's Name:

Dog Cat Birthdate:

Dog Cat Birthdate:

Male Female Spayed/Neutered? Yes No

Male Female Spayed/Neutered? Yes No

Breed:

Breed:

Color:

Color:

Microchipped? Yes No Number:

Microchipped? Yes No Number:

**If we are examining more than 2 of your pets today, please use the back of this form to provide information about your other animals. Thank you!**

Does your pet(s) have any special needs? If so, please list them:

When & where was your pet(s) last vaccinated?

Do you hereby grant Truesdell Animal Care Hospital & Clinic permission to obtain previous veterinary medical records for your pets? Yes No If yes, from where? Phone:

**How Did You Find Us?**

Drove/Walked By

Phone Book

Internet

Yelp

Humane Society

Vet Pets

Facebook

Postcard

Client:

Employee:

Other Hospital/Doctor:

Other:

**I hereby agree that all of the above information is correct to the best of my knowledge, and I assume responsibility for the animal(s) listed.**

Owner or responsible party signature

Date