



CLIENT INFORMATION FORM

Thank You for bringing your pet to Dentistry for Animals. We require payment in full at the time of service. We regret that we do not have a payment plan.

In order to establish an accurate file, please complete the following form.

PET INFORMATION

Pet's Name: _____ Date of Birth: _____ Age: _____

Species: _____ Breed: _____ Color/Markings: _____

Sex: _____ Spayed/Neutered: Yes No

Referring or regular Veterinarian: _____

Please check any of the following that apply to previous or current conditions:

- | | | |
|---|---|--|
| <input type="checkbox"/> Vaccination Reaction | <input type="checkbox"/> Drug or Food Allergies | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Anesthetic Complications | <input type="checkbox"/> Trauma/Fractures | <input type="checkbox"/> Major Surgeries |

Other: _____

Other: _____

PERSONAL INFORMATION

Name: _____
Last First

Address: _____ City: _____ Zip: _____

Mailing Address (if different): _____

E-mail Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

Employer Name and Address: _____

California driver's License Number: _____ Social Security Number: _____

Spouse/Co-owners Name: _____ Spouse's Work Phone: _____

Spouse's Employer and Address: _____

Method of payment: Cash Check Credit Card (MC, Visa, American Express)

I/We have filled out all requested information to the best of our knowledge and have read and understand the payment policy of Dentistry for Animals.

Owner's Signature

Date