



# Animal Medical Hospital of Poway

## Personalized Care for Your Pet

Thank you for giving us the opportunity to care for your pet.

In order for us to do so, please provide us with the following information:



### CLIENT INFORMATION

Name: (First, Last) \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Residence Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Spouse/Other Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ If necessary, may we call you at work? Yes or No  
 E-mail Address: \_\_\_\_\_

How did you become aware of our hospital? Location \_\_\_\_\_ Shelter/Humane Society \_\_\_\_\_  
 Yellow Book \_\_\_\_\_ Yellow Page Web site \_\_\_\_\_ Our Website \_\_\_\_\_ Other \_\_\_\_\_  
 Client Referral \_\_\_\_\_ If so, who? \_\_\_\_\_

### PATIENT INFORMATION

Pet Name: \_\_\_\_\_ Dog Cat Other \_\_\_\_\_  
 Breed: \_\_\_\_\_  
 Color: \_\_\_\_\_ Sex: Male Female Neut. Male Spayed Female  
 Birthdate/Age: \_\_\_\_\_

Please enter dates for the following vaccinations:

	Canine		Feline
Dap/p +C	_____	FVRCP	_____
Bordatella	_____	Leukemia	_____
Lyme	_____	Rabies	_____
Lepto	_____		
Rabies	_____		
Rattlesnake	_____		

Is your pet currently using any type of flea control? Yes or No If yes please specify \_\_\_\_\_  
 Is your pet on Heartworm preventative medication? Yes or No If yes please specify \_\_\_\_\_  
 Do you brush your pets teeth? If yes, how often? \_\_\_\_\_  
 Is your pet on any prescribed medications? \_\_\_\_\_  
 Please list any other medical problems your pet has had: \_\_\_\_\_

### ALL FEES ARE DUE UPON THE RELEASE OF THE PATIENT

\_\_\_\_\_  
 Client Signature Date

WE ACCEPT MASTERCARD-VISA-DISCOVER-AMERICAN EXPRESS-DEBIT CARDS

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