



Patient Intake Form

Client Information

First Name _____ Last Name _____ M.I. ____ Spouse _____
Street Address _____
City _____ State _____ ZIP _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-mail _____ Employer _____
How did you hear about us? Yellow Pages Walk-In Friend — Their Name _____
Referring Veterinarian _____ Family Veterinarian (if different) _____

Patient Information

Animal's Name _____ Species Canine Feline Other _____
Breed _____ Sex: Male Female Male Neutered Female Spayed Birthdate or Age _____
Initial Presenting Problem _____

TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE

I hereby authorize VRCC practices to perform medical and initial diagnostic/surgical procedures on this animal as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors and assistants.

If you were referred to our hospital by another veterinarian, they will require a summary of your pet's care and treatment in order for your pet's care to continue without interruptions. VRCC considers that your identification of a referring veterinarian implies your authorization to release records and information to that referring veterinarian.

We are leaders and teachers in the veterinary medicine field, thus case information and/or photos may be used in teaching, forms, continuing education, Web site, veterinary literature, and the like. I authorize the release of case/patient information for such purposes; patient confidentiality (names withheld) will be maintained.

In the event that I sell this animal to another owner, I authorize release of medical information to the new owner.

FINANCIAL POLICY

Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance. The balance is due upon discharge from the hospital. You may pay by cash, personal check (with proper identification), accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.

In the event that payment is not made at the time of service, it is our policy to apply a service charge to accounts with a balance over 45 days old. A service charge of \$3.00 per month and 1.5% of the outstanding balance will be charged to your account if not paid in full.

All returned checks will incur a charge of \$25.00.

NAMES OF INDIVIDUALS AUTHORIZED TO PICK UP ANIMAL FROM VRCC:

Name: _____ Name: _____

I understand that the owner or agent is financially responsible to the applicable VRCC practices for all charges relating to this animal. I have read and agree to the treatment authorization. I have also read and accept the financial obligations.

Signature

Date



Veterinary Cancer Specialists — Medical History

To help us provide the best care, please fill in the following:

How long have you owned your pet?	
Where was your pet obtained?	
Is your pet kept primarily indoors or outdoors?	
What does your pet eat and how much?	
Is your pet is neutered/spayed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, at what age?	
b. If not, when was her last heat cycle?	
Prior to this illness, has your pet ever been treated for any major medical problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, what type and when?	
Current medications and dosages:	
Has your pet been boarded or hospitalized recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your pet now taking preventative for heartworm disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet lost stamina recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet been vomiting frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet lost or gained any weight recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet's appetite increased or decreased recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your pet straining to defecate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet been scratching/itching?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet had any seizures or convulsions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet's gait changed recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet shown any changes in attitude or behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any swelling or masses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, where?	
Has your pet had unusual/unexpected reactions to medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet been sneezing excessively?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there any blood in or discoloration of your pet's urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have there been recent changes in the frequency, amount or color of your pet's bowel movements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If your pet is female, has there been any abnormal vaginal discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet had any discharge from the eyes or nose?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your pet drinking more water than usual?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet been coughing or showing difficulty breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your primary concern about your pet?	

Thank you. A thorough medical history is essential if proper therapy is to be administered to your pet.