Welcome to Main St Animal Hospital

We are glad to have the opportunity to care for your pet.
To ensure your pet gets the best care we can offer, please fill out this form completely.

Client Information:

Owner's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (____) _____ Work Phone: (___) _____

Email: _____

Employer: _____

Pet Health History:

Pet's Name: _____ Age:_____

Type: _____ Breed: _____Color: _____

Sex: M ☐ F ☐ Neutered/Spayed: Y ☐ N ☐

Vaccination History:

☐ Distemper Date:__/__/__ ☐ Parvo Date:__/__/__ ☐ Rabies Date:__/__/__

☐ FVRCP Date:__/__/__ ☐ Leukemia Date:__/__/__ ☐ Bordetella Date:__/__/__

Primary reason for visit today:_____

_____

_____

Authorization:

I hereby authorize Dr. Schaar to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges Incurred in the care of the animal. I also understand that all professional fees due at the time services are rendered.

Signature of responsible party_____ Date:_____

The information on this form is strictly confidential and is to be used only by this practice to provide care and treatment for your pet.