

Welcome to Bayview



CLIENT INFORMATION:

DATE: _____
NAME _____
ADDRESS: _____

CITY: _____ STATE _____ ZIP _____
HOME# _____ CELL# _____ EMAIL _____
EMPLOYER _____ WK# _____
SPOUSE OR OTHER CONTACT _____ PH# _____
WERE REFERRED BY SOMEONE?? IF YES, WHO?? _____
PLEASE CHECK YES AND INITIAL IF YOU RELEASE US TO USE PHOTOS OF YOUR PET ON OUR WEBSITE,
FACEBOOK OR OTHER SOCIAL MEDIA. NO YES _____

PET INFORMATION:

NAME _____ DOG CAT
BREED _____ COLOR _____
DOB _____ MALE FEMALE SPAYED/NEUTERED YES NO
VACCINATIONS & DATES: DHLPP/FVRCP _____ RABIES _____ BORDATELLA _____
IS YOUR PET ON HEARTWORM PREVENTATIVE? NO YES TYPE _____
CURRENT MEDICATIONS/SPECIAL DIETS _____
REASONFORVISIT _____

PLEASE CHECK ANY SYMPTOMS OR PROBLEMS YOU HAVE NOTICED WITH YOUR PET:

- | | | |
|---|--|---|
| <input type="checkbox"/> APPETITE LOSS | <input type="checkbox"/> GAGGING | <input type="checkbox"/> THIRST |
| <input type="checkbox"/> BEHAVIORAL CHANGES | <input type="checkbox"/> LIMPING | <input type="checkbox"/> URINATION INCREASE |
| <input type="checkbox"/> BREATHING PROBLEMS | <input type="checkbox"/> LOSS OF BALANCE | <input type="checkbox"/> VOMITING |
| <input type="checkbox"/> COUGHING | <input type="checkbox"/> SCOOTING | <input type="checkbox"/> WEAKNESS |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> SCRATCHING | <input type="checkbox"/> WEIGHT LOSS |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> SHAKING HEAD | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> EYE DISORDERS | <input type="checkbox"/> SNEEZING | <input type="checkbox"/> OTHER _____ |

AUTHORIZATION

I HEAR BY AUTHORIZE THE VETERINARIAN TO EXAMINE, PRESCRIBE FOR, OR TREAT THE ABOVE DESCRIBED PET. I ASSUME ALL RESPONSIBILITY FOR ALL THE CHARGES INCURRED IN THE CARE OF THE ANIMAL. I ALSO UNDERSTAND THAT **ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. ANY BALANCES WILL ACCRUE A MONTHLY SERVICE FEE.**

ALL ANIMALS MUST HAVE IMMUNIZATIONS BY A LICENCED VETERINARIAN WITHIN THE PAST YEAR AND BE FREE OF INTERNAL AND EXTERNAL PARASITES BEFORE BEING ADMITTED INTO THE HOSPITAL.

SIGNATURE OF CLIENT RESPONSIBLE FOR PET _____ DATE _____