



FAIRFIELD ANIMAL HOSPITAL
 15040 FAIRFIELD VILLAGE DRIVE, SUITE 100
 CYPRESS, TX 77433

MIKE HICKS, D.V.M.

SANDRA HARRIS, D.V.M.

"COMPASSIONATE CARE FOR YOUR PET FAMILY MEMBER."

Client Information

Owner Name _____ Co-Owner/Spouse Name _____

Home Address _____ City _____ State _____ Zip _____

Home Phone Number _____ E-mail _____

How did you learn of our clinic? Yellow pages Sign Fairfield Gazette Internet

Current Client Recommended by whom: _____

Owner Information

Co-Owner/Spouse Information

Employer _____

Employer _____

Work Phone _____

Work Phone _____

Cellular Phone _____

Cellular Phone _____

Additional phone numbers _____

Patient Information

Patient Name _____

Dog Breed _____ Circle one Female/Spayed Male/Neutered

Cat Breed _____ Circle one Female/Spayed Male/Neutered

Other Species _____ Circle one Female/Spayed Male/Neutered

Birthdate _____ Age _____ Color _____

How long have you owned pet? _____ Where did you acquire pet? _____

Currently on a Heartworm Preventative? _____ If yes, what type/brand _____

Vaccinations current? _____ Reason for visit (primary complaint) _____

What is your pet's diet? _____

Does your pet have any **drug allergies** or **medical problems** that we should know about? _____

Please list any medications your pet is currently on _____

Any other pets at home? If yes, please list _____

Please check any symptoms or problems that you have noticed about your pet.

- | | | |
|---|---|---|
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Limping | <input type="checkbox"/> Thirst and/ or Urination Increased |
| <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"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Seems Depressed | _____ |

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner _____ Date _____