



# Client Information Sheet

Acct #/CCS \_\_\_\_\_

## CLIENT INFORMATION

Name(s): \_\_\_\_\_ Home phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Secondary owner: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Driver's License# and Issuing state: \_\_\_\_\_

Have you been to our hospital before?  yes  no

Referred by:  Phone book  Television/Radio  Family veterinarian  Location  Family/Friend  Internet  Other: \_\_\_\_\_

## PATIENT INFORMATION

Pet Name: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Age: \_\_\_\_\_

Sex:  M  F Spayed/Neutered:  Yes  No

Reason for visit today: \_\_\_\_\_

Current medications: \_\_\_\_\_ Dose and frequency: \_\_\_\_\_

Has your pet ever traveled out of state?  yes  no

Please check any symptoms or problems that you have noticed in your pet:

Behavioral changes  Depression  Weight Loss  Weakness  Loss of appetite  Lethargy

Gagging  Vomiting  Diarrhea  Breathing problems/coughing/sneezing  Seizures  Limping

Increased drinking  Urination increase/decrease  Loss of balance  Other \_\_\_\_\_

## PRIMARY CARE VETERINARIAN

Name of Practice: \_\_\_\_\_ Doctor: \_\_\_\_\_

## AUTHORIZATION

I am 18 years of age or older and do hereby authorize the veterinarian and technicians to examine my pet and administer treatment as is considered necessary for my pet's condition. A treatment plan of care options will be discussed prior to any treatments. In life-threatening situations, stabilizing care may be instituted upon arrival, but no invasive or diagnostic treatment will be undertaken until it has been discussed with me. I also authorize WestVet to fax or e-mail my pet's medical record to my family veterinarian for the purpose of sharing information only. I understand that WestVet may refuse services for any reason. Any pet left in the hospital for a period of 10 days or more will be considered abandoned under Idaho law.

I hereby release WestVet of all liability in the event of injury, bite, fall or other circumstance that might cause injury while I/my family members am/are a visitor or patron in the hospital. I assume all risks and will take necessary precautions regarding safety in all non-public areas of the hospital for myself and my family.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM