



Client and Patient Information

404 S. Edgemoor, Bldg 100
Wichita, Ks 67218

*Thank you for giving us the opportunity to care for your pet(s).
So that we may become better acquainted, please complete the following:*

Name _____ Spouse/Co-Owner _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Work Phone _____ Spouse/Co-Owner's Cell Phone _____
 Employer _____ Spouse/Co-Owner's Employer & Phone _____
 Emergency Contact _____ Emergency Contact Phone _____

E-Mail Address _____

How did you become aware of our clinic? Yellow Pages __ Web Site __ KMUW __ Google __ Facebook __ Other _____
 Personal Recommendation (*Whom may we thank?*) _____

	Pet 1		Pet 2		Pet 3	
Name:						
Breed:						
Date of Birth:						
Color:						
Sex:						
Spayed (F) Neutered (M)	YES NO	YES NO	YES NO	YES NO	YES NO	
Microchip	YES NO	YES NO	YES NO	YES NO	YES NO	
Previous Medical Records? (If so where)	YES NO	YES NO	YES NO	YES NO	YES NO	

Any previous serious illnesses or surgeries? _____
 Any allergies to vaccinations or medications? _____
 Is your pet on any special diets or medications? _____

**I agree to pay any costs and charges necessary for the collection of any amount not paid when due.
 A full payment is required upon rendering of services. We do NOT carry open accounts.
 We accept the following: Cash, Check, Visa, MasterCard, Discover, American Express, Care Credit**

Signature of owner or authorized representative:

Signed: _____ Date: ____/____/____

*THANK YOU for bringing your pet to our hospital. We hope you are pleased with our services and facilities.
 We would appreciate your letting us know how we might improve them.*