All Animal Veterinary Services

2264 Route 32
Modena, NY 12548

New Patient Information Form

Owner: _____ Spouse/other: _____

Address/City/State/Zip: _____

Home phone: _____ Cell phone:_____ Spouse's cell phone:_____

Email: _____

Emergency contact: _____ Phone: _____

How did you hear about our clinic? Internet Search _____ Veterinarian _____ Exterior Sign _____ Flyer _____

_____ Friend/Family (**Please Specify:**_____) Other_____ (Please specify: _____)

How would you like your reminders? _____ Text _____ Email _____ US Mail _____ Phone

Number of pets: Dog(s): ____ Cat(s): ____ Other (please specify species) : _____

Name of pet: _____ Dog ____ Cat ____ Other _____

Breed: _____ Color: _____ D.O.B. or Age: _____ Weight: _____

Please circle all that apply: Male / Female / Unknown Neutered / Spayed / Intact / Unknown Microchip ID #: _____

Vaccine history (dates):

Dog	Cat	Lab Test(s)
DHP-P _____	FVRCP-P _____	Fecal _____
Rabies _____	Rabies _____	Heartworm Test _____
Kennel Cough _____	Leukemia _____	FeLV/FIV Test _____

Previous veterinarian, clinic, or animal hospital: _____

What type of flea/tick/heartworm preventative is your pet on? _____

Is your pet on any other medication? If yes, please specify: _____

Please list any known allergies: _____

Please list any past or current medical conditions: _____

Describe your pet's diet: _____

Please circle any symptoms or problems you have noticed about your pet:

Behavior problems	Lack of appetite	Sneezing	Bleeding gums	Limping	Coughing
Breathing problems	Increased thirst/urination	Loss of balance	Vomiting	Diarrhea	Scooting
Weakness	Eye bulging or bloodshot	Seems depressed	Seems anxious	Gagging	Shaking head

Other: _____

I hereby authorize Dr. Eleanor Acworth, DVM to examine, prescribe for, and/or treat the pet described above. 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. I have read the provided information and fully understand the possibility of vaccine, medication, and/or treatment reactions.

$25 CANCELLATION FEE WILL BE APPLIED TO MISSED OR CANCELED APPOINTMENTS WITHOUT 24 HOURS ADVANCE NOTICE

Signature of owner: _____ Date: _____