FAIRFIELD ANIMAL HOSPITAL

Compassionate Care for Your Pet Family Member

Dr. Mike Hicks, Dr. Sandra Harris and Dr. Andrew Faist
14940 Mueschke Rd.
Cypress, TX 77433
Phone: 281-256-3150 **Fax**: 281-213-3625 E-mail: info@myfairfieldvet.com
Myfairfieldvet.com

Client Information

Owner Name _____ Co-Owner/Spouse Name _____
Home Address _____ City _____ State _____ Zip _____
Main Phone Number _____ **E-mail** _____
CELL PHONE FOR TEXT REMINDERS: Same ? or _____
How did you hear about us? ☐I am currently a client ☐Internet Search ☐Sign ☐Fairfield Gazette ☐Yellow Pages ☐Facebook
☐I was recommended by: _____ Previous Veterinarian: _____

Owner Information _____ **Co-Owner/Spouse Information** _____
Employer _____ Employer _____
Work Phone _____ Work Phone _____
Cell Phone _____ Cell Phone _____

Patient Information

Patient Name _____ Species ☐Dog ☐Cat ☐Other _____
Sex ☐Female ☐Spayed ☐Male ☐Neutered **Breed** _____ Color _____
How long have you owned pet? _____
Where did you acquire pet? _____ Birthdate _____ Age _____
Currently on **heartworm prevention**? ☐Yes ☐No If yes what type/brand? _____
Vaccinations current? ☐ Yes ☐No Reason for visit (primary complaint) _____
What is your pet's diet? _____
Does your pet have any **drug allergies** or **medical problems**? _____
Please list **any medications** your pet is on: _____

IS YOUR PET MICROCHIPPED? ☐ YES ☐ NO WOULD YOU LIKE A MICROCHIP TODAY ☐ YES ☐ NO

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

☐ Behavior Problems	☐ Lack of Appetite	☐ Sneezing
☐ Bleeding Gums	☐ Limping	☐ Increased thirst
☐ Breathing Problems	☐ Loss of Balance	☐Increased urination
☐ Coughing	☐ Scooting	☐ Vomiting
☐ Diarrhea	☐ Scratching	☐ Grooming
☐ Eye Bulging or Bloodshot	☐ Seems Depressed	☐ Other _____

How do you plan to pay today (Please Circle) **Cash Credit Debit Care Credit**

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 _____