Compassionate Care for Your Pet Family Member

Dr. Mike Hicks, Dr. Sandra Harris and Dr. P.J. Wonder
15040Fairfield Village Drive, Suite 100
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 ____
How did you hear about us? ☐I am currently a client ☐Internet Search ☐Sign ☐Fairfield Gazette ☐Yellow Pages ☐Facebook
☐I was recommended by: _______________________________________

Owner Information

Employer __________________________________
Work Phone ________________________________
Cell Phone _________________________________

Co-Owner/Spouse Information

Employer ______________________________
Work 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** that we should know about? ______________________________
____
Please list any medications your pet is on ____
Any other pets at home? If yes, please list ____
Please check any symptoms or problems that you have noticed about your pet

☐ Behavior Problems
☐ Bleeding Gums
☐ Breathing Problems
☐ Coughing
☐ Diarrhea
☐ Eye Bulging or Bloodshot
☐ Lack of Appetite
☐ Limping
☐ Loss of Balance
☐ Scooting
☐ Scratching
☐ Seems Depressed
☐ Sneezing
☐ Thirst and/or Urination Increased
☐ Vomiting
☐ Weakness
☐ Other _______________
____

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 _________________________