

ANIMAL MEDICAL CENTER OF PLANO

5809 Coit Road
Plano, Texas 75093
972-985-8448 phone / 972-758-5448 fax
animalmedcenter@yahoo.com

Client Information

Date: _____ Driver License #: _____ Birthdate: _____
Name (Last Name First): _____
Spouse's Name: _____
Address: _____ City/State/Zip: _____
Home Phone: () _____ Employer: _____
Work Phone: () _____ Employer's Address: _____
E-mail Address: _____
Cell Phone: () _____ Additional Phone: _____
Emergency Contact Name: _____ Phone: () _____

How did you learn about our practice? _____
If it was from one of our clients, whom may we thank? _____
Number of pets (please specify by type): _____
Primary reason for visit: _____

Pet Information

Pet's Name: _____ · Dog · Cat · Other _____
Sex: · M · F Age: _____ Birthdate: _____ Breed: _____
Color: _____ Neutered/Spayed: · Yes · No If yes, at what age? _____
What age was pet obtained? _____
From: · Friend · Breeder · Pet Shop · Humane Society · Other _____
Reason for obtaining pet (check all that apply): · Companion · Protection · Breeding
· Show · Other _____
Brand or description of your pet's diet: _____
List your pet's current medication: _____
Pet's History (check only those that pet has received):
· Distemper Vaccine · Feline Leukemia Test · Prior Surgery: _____
· Parvovirus Vaccine (Dog) · FVRCP Vaccine (Cat) · Prior Illness: _____
· Rabies Vaccine (Dog/Cat) · Dental · Other _____
(Please see second sheet for additional pet information.)

Authorization

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 the animal. I also understand that ***ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.***

Signature of client responsible for pet(s) _____ Date _____

Please provide a copy of driver's license or ID.