

# Ark Angel Animal Hospital New Client Information Form

**SEND PATIENT RECORDS TO US:**

If your pet is coming in for their first visit or is returning to us after some time, please have his or her most recent (last 1-2 years') medical records sent to us at [aaahvet@gmail.com](mailto:aaahvet@gmail.com) or by fax to (508) 983-1703. **Please reiterate to your previous veterinarian's office staff that we need the Dr.'s notes, lab work results, radiographs etc.** The earlier we have them, the more likely it will be that our Doctor will be able to review them prior to your appointment.

Please PRINT legibly		<u>CLIENT INFORMATION</u>	
You are the Client; your Pet is the Patient			
<b>Date &amp; Time of Scheduled Appointment:</b>			
Client's Full Name:			Owner? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Address on Cape:			
Mailing Address:			
Phone Numbers:	Home:	Cell:	Work:
Email Address:			
Preferred method of contact:	<input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Work phone <input type="checkbox"/> Email		
Spouse/Partner's Full Name:			Owner? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Address on Cape:			
Mailing Address:			
Phone Numbers:	Home:	Cell:	Work:
Email Address:			
Preferred method of contact:	<input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Work phone <input type="checkbox"/> Email		
Amount of time on Cape Cod:	<input type="checkbox"/> Year Round Resident <input type="checkbox"/> Seasonal Resident <input type="checkbox"/> Annual Vacation <input type="checkbox"/> One Time Visit <input type="checkbox"/> Other		
How did you hear about us?			
<b>REASON FOR TODAY'S OFFICE VISIT</b>			

## PATIENT INFORMATION

MULTIPLE PATIENTS MUST BE LISTED INDIVIDUALLY.      Your Pet is the Patient; you are the Client

Pet's Name:				
Species:	<input type="checkbox"/> Canine <input type="checkbox"/> Feline <input type="checkbox"/> Other (please describe)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Neutered <input type="checkbox"/> Spayed	<input type="checkbox"/> Microchip <input type="checkbox"/> Tattoo
Breed:	Color:	Markings:		
Age:	Date of Birth:			
Known drug allergies:				
Current Heartworm Prevention:			Current Flea & Tick Prevention:	
Current Medications (or supplements)	Medication	Dosage (mg or ml)	Frequency	
	Medication	Dosage (mg or ml)	Frequency	
	Medication	Dosage (mg or ml)	Frequency	
	Medication	Dosage (mg or ml)	Frequency	
	Medication	Dosage (mg or ml)	Frequency	
Medical Conditions, Surgeries, past and present:				
Current diet:				
Primary or Previous Veterinarian/ Clinic Name & Location:			Phone:	

Patient #2 (if applicable)			
Pet's Name:			
Species:	<input type="checkbox"/> Canine <input type="checkbox"/> Feline <input type="checkbox"/> Other (please describe)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Neutered <input type="checkbox"/> Spayed <input type="checkbox"/> Microchip <input type="checkbox"/> Tattoo
Breed:	Color:	Markings:	
Age:	Date of Birth:		
Known drug allergies:			
Current Heartworm Prevention:		Current Flea & Tick Prevention:	
Current Medications (or supplements)	Medication	Dosage (mg or ml)	Frequency
	Medication	Dosage (mg or ml)	Frequency
	Medication	Dosage (mg or ml)	Frequency
	Medication	Dosage (mg or ml)	Frequency
	Medication	Dosage (mg or ml)	Frequency
Medical Conditions, Surgeries, past and present:			
Current diet:			
Primary or Previous Veterinarian/ Clinic Name & Location:			Phone:

If you have additional pets visiting the doctor during this scheduled appointment, please print and complete additional copies of this page.