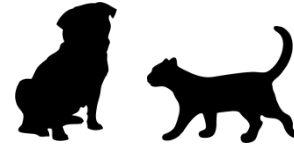




Welcome to Flossmoor Animal Hospital



Thank you for giving us an opportunity to care for your pet.



Please complete the following so that we can better care for you and your pet:

Mr./Mrs./Ms./Dr. _____ Today's Date _____
 Owner's First Name _____ Spouse _____ Last Name _____
 Address _____ City _____ State _____ Zip _____
 Phone (home) _____ Phone (work) _____ Cell _____
 Phone (spouse's work) _____ Cell (spouse's) _____
 Email _____ Social Security No. (If paying with check) _____
 Employer _____ Address _____ City _____ State _____ Zip _____
 Employer _____ Address _____ City _____ State _____ Zip _____

How did you hear about us?

- Friend's Name _____ Address _____ Phone _____
- Phone Book _____
- Location _____
- Internet _____
- Other _____

Pet's Name	Breed	M/Female	Color	Birthday Day/Month/Yr.	Spayed/ Neutered	Date of last Vaccines	Where
1. _____	_____	_____	_____	_____	Y or N _____	_____	_____
2. _____	_____	_____	_____	_____	Y or N _____	_____	_____
3. _____	_____	_____	_____	_____	Y or N _____	_____	_____

To provide you and your pet with the best possible care and customize your pet's health needs, we have a few specific medical questions:

- | | | | |
|---|--|------------|----|
| Does your pet have any of the following symptoms? | Does your pet drink more water than a year ago? | Yes | No |
| <input type="checkbox"/> Loose Stools | Have you noticed changes in pet's sleep habits? | Yes | No |
| <input type="checkbox"/> Vomiting | Does your pet have trouble with stairs or stiffness? | Yes | No |
| <input type="checkbox"/> Coughing | What food is your pet on? _____ Brand? | | |
| <input type="checkbox"/> Heavy Breathing | How much do you feed your pet? _____ Cups | How often? | |
| <input type="checkbox"/> Sneezing | Do you give your pets any supplements? | Yes | No |
| <input type="checkbox"/> Eye Discharge | Do you give your pets any vitamins? | Yes | No |
| <input type="checkbox"/> Itching | Do you brush your pet's teeth? | Yes | No |
| <input type="checkbox"/> Hair Loss | Is your pet currently protected from heartworms? | Yes | No |
| <input type="checkbox"/> Fleas or Ticks | Is your pet currently on a flea and tick preventative? | Yes | No |
| <input type="checkbox"/> Skin Growths | How often do you bathe your pet or trim nails? | | |
| <input type="checkbox"/> Bad Breath | Does your pet have a microchip? | Yes | No |
| | If yes Microchip Number _____ | | |

- Does your pet exhibit any of the following behaviors?
- Unwanted aggression
 - Excessive barking
 - Marking
 - House-soiling
 - Other _____

How would you prefer to pay for your services today? (circle) Cash Check Visa/MasterCard/Discover Care Credit

ALL FEES ARE DUE WHEN SERVICES ARE RENDERED.
THANK YOU FOR YOUR COOPERATION IN THIS MATTER.
CREDIT CARDS OR CARE CREDIT ARE ACCEPTED FOR THOSE INTERESTED IN DELAYING PAYMENT.