PARLIAMENT ANIMAL HOSPITAL

You are a:
New patient ☐ Returning patient ☐ Updating information ☐

Client Information:

First Name: _____ Permit to Email: _____

Last Name: _____ Phone #:(H) _____ (C)_____

Address: _____ Unit #_____ Postal Code: _____ City: _____

Emergency Contact Name: _____ Emergency Phone #_____

Emergency contact-person has authority over financial and medical decision making. ☐ Yes ☐ No

Number of pets in your household: # of cats: ____ # of dogs: ____ others: _____

How did you hear about our hospital? Website ☐ *Friends/Family* ☐ *Walk-in* ☐ *Other* ☐ _____

Pet Information:

Pet Name: _____ Canine ☐ Feline ☐ Other ☐ _____

Sex: Male ☐ Female ☐ DOB: _____ Breed: _____

Colour _____ Neutered / Spayed: Yes ☐ No ☐ If yes, at what age? _____

Please describe your pet's diet: Canned food ☐ Dry food ☐ Food brand_____

Primary reason for your visit: _____

Please list your pet's current medication(s): _____

Please list any symptoms/problems you have noticed with your pet: _____

_____

Please tell us about your Pet's medical history_____

_____

Is your pet vaccinated for Rabies? Yes ☐ No ☐

Has your pet ever bitten anyone/other animals? Yes ☐ No ☐

Date: _____ Signature: _____