620 W. WEBSTER AVE. | CHICAGO, IL 60614 | 773-327-5024 | OZANIMALHOSPITAL.COM

Client Information

Last Name_____First Name _____

Additional Owner Last Name_____First Name _____

Address_____City, State, Zip_____

Primary Phone Number_____☐ Cell ☐ Home ☐ Work

Alternate Phone Number_____☐ Cell ☐ Home ☐ Work

EMAIL_____(Note: This is our primary means of sending you reminder notifications)

Whom may we thank for referring you to us?

☐ Walk by/Sign ☐ Yelp ☐ Google Search

☐ Friend/Family Referral-Please provide their name so we can thank them!_____

☐ Facebook ☐ Word of mouth ☐ Other-Please Describe:_____

Patient Information

Pet's Name_____☐ Canine ☐ Feline

☐ Male ☐ Female ☐ Spayed or Neutered? Date if known_____

Breed_____Color_____

Age or Date of Birth_____Microchip? ☐ Yes ☐ No ☐ Unsure

Microchip Number_____

Are there any other pets in the household? ☐ Yes | ☐ No Describe_____

Patient History

Does your pet ever go outside? ☐ Yes | ☐ No

Does your pet ever go to a boarding or day care facility? ☐ Yes | ☐ No

Vaccine/Testing History:

Bordetella (Kennel Cough) ☐ Yes | ☐ No | ☐ Unsure Date:_____

Rabies (1 year) ☐ Yes | ☐ No | ☐ Unsure Date:_____

Rabies (3 year)	☐ Yes | ☐ No | ☐ Unsure	Date:_____
Leptosporosis	☐ Yes | ☐ No | ☐ Unsure	Date:_____
Distemper/Adenovirus/Parvovirus (K9)	☐ Yes | ☐ No | ☐ Unsure	Date:_____
FVRCP (Feline distemper combo)	☐ Yes | ☐ No | ☐ Unsure	Date:_____
Lyme	☐ Yes | ☐ No | ☐ Unsure	Date:_____
Heartworm Testing	☐ Yes | ☐ No | ☐ Unsure	Date:_____
Feline Leukemia Vaccine	☐ Yes | ☐ No | ☐ Unsure	Date:_____
Feline Leukemia/FIV Testing	☐ Yes | ☐ No | ☐ Unsure	Date:_____
Professional Dental Cleaning?	☐ Yes | ☐ No | ☐ Unsure	Date:_____
Blood work done?	☐ Yes | ☐ No | ☐ Unsure	Date(s):_____
Heartworm monthly preventative	☐ Yes | ☐ No | ☐ Unsure	Product:_____
Flea/Tick monthly preventative	☐ Yes | ☐ No | ☐ Unsure	Product:_____
Any known allergies	☐ Yes | ☐ No _____	

Please list all your pets current medications/supplement and bring them in with you to your appointment

Please list all prior illnesses/surgeries

Please list your pet's diet including treats

What is the primary reason for today's visit?

Have you noticed any of the following symptoms?

☐Increased Thirst ☐Increased Urination ☐Sneezing ☐Coughing ☐Vomiting ☐Diarrhea
☐Change in Appetite ☐Breathing Changes ☐Bad Breath ☐Depression ☐Scooting ☐Limping
☐Weight Gain/Loss ☐Accidents in Home ☐Itching/Biting ☐Rash/Sores ☐Balance Issue ☐Bleeding
☐Head Shaking ☐Eye Irritation ☐Seizure ☐Odor ☐Behavioral Issue

Other/Further Details:

Please share any additional comments.

Treatment Authorization

I hereby authorize Oz Animal Hospital staff to examine and treat this patient as mutually agreed upon. I understand that payment for all fees are due at the time services are rendered.

Signature Date

Optional Photo/Video Authorization

We can't help but want to spread the word how adorable our patients are! Your signature here grants full permission to Oz Animal Hospital to utilize photographs or images (last name and medical conditions shall be kept confidential) of this patient and/or yourself for use in any publication, social media, or advertising medium. I waive all right of privacy or compensation in connection with any used images.

Signature Date