



Welcome to Kaibab Animal Hospital

Thank you for giving us the opportunity to care for your animal family members. We'll be happy to answer any questions you have regarding your pet's health and well-being.

(Please Print)

Owner's Name _____ Spouse/Other _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____ County _____

Home Phone (____) _____ Cell (____) _____ Work (____) _____

Employer's Name and Address _____

E-mail Address _____

Driver's License # _____ Social Security # _____

In case of EMERGENCY, please contact _____ at phone number (____) _____

How did you first hear of our hospital?

- Individual: Someone we may thank? _____
- AAHA referral Hospital Sign (Drive By) Yellow Pages
- Maricopa County Animal Care and Control Website Other _____

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

We gladly prepare a written estimate of cost for any treatments or procedures.

Payment Method: Cash Personal Check VISA, MasterCard, American Express, or Discover

I hereby authorize the veterinarian to examine, prescribe for or treat my pet. I assume responsibility for all charges incurred in the care of my pet. I also understand and agree that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner or Responsible Party

Date

Kaibab Animal Hospital provides general and emergency care from the hours of 7:00am – 7:00pm Monday - Friday, 8:00am – 2:00pm on Saturdays and 11:00am – 3:00pm on Sundays. We do not employ any after-hours staff.

Thank you for entrusting us with your pet's care!

ANIMAL MEDICAL HISTORY

	Pet #1	Pet #2	Pet #3
Pets Name			
DOG or CAT			
Breed			
Colors/Markings			
Age			
Date of Birth (if known)			
Gender (<i>circle ONE</i>)	Male / Female	Male / Female	Male / Female
Neutered / Spayed	Y / N	Y / N	Y / N
Length of time owned			
Diet (kind of pet food)			
Medications / Supplements			
Hours spent outside daily			
Where did you get your Pet			
Previous Vet:	Name: _____ Phone: () - _____ - _____		

TESTS / PROCEDURES	Test Type - Date Done	Test Type - Date Done	Test Type - Date Done
Heartworm Test (<i>Last Done</i>)			
Blood work (<i>Type & Date</i>)			
Fecal Exam (<i>Last Done</i>)			
Dentistry (<i>Last Done</i>)			
Prior Illness (<i>What/When</i>)			
Prior Surgery (<i>What/When</i>)			
Other: _____			
Known Chronic Conditions			

VACCINATIONS	DATE GIVEN	DATE GIVEN	DATE GIVEN
Distemper/Parvo Combo			
Bordetella (Kennel Cough)			
Rabies			
FVRCP (Cat only)			
Feline Leukemia Vaccine			
Feline Leukemia Test			
Other Vaccines: _____			