



Garrison Animal Care Clinic

Client Information Record

DATE: _____

CLIENT NAME(S): _____

MAILING ADDRESS: _____

CITY, STATE, ZIPCODE: _____

EMAIL ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

REFERRED BY: _____

PET'S NAME: _____ DOG: _____ CAT: _____ OTHER: _____

BREED: _____ SEX: _____ SPAYED/NEUTERED: _____

COLOR: _____ DOB/AGE: _____ DIET: _____

DOGS

CATS

DISTEMPER/HEP/LEPTO: _____

FELINE DISTEMPER: _____

BORDATELLA: _____

RHINO/CALICI: _____

CORONA: _____

FELINE LEUKEMIA: _____

PARVOVIRUS: _____

RABIES: _____

RABIES: _____

LYMES: _____

MEDICAL HISTORY/SURGERIES/ALLERGIES/INJURIES: _____

REASON FOR VISIT: _____

NOTES:

ALL ANIMALS MUST HAVE HAD ALL IMMUNIZATIONS WITHIN PAST YEAR AND BE FREE OF INTERNAL AND EXTERNAL PARASITES BEFORE BEING ADMITTED TO THE HOSPITAL.

FOR THE SAFETY OF CLIENTS AND PATIENTS, ALL ANIMALS MUST BE ON LEAD OR IN SECURE CARRIER WHEN PRESENTED FOR TREATMENT/ARE.

METHOD OF PAYMENT:

CASH _____ CHECK _____ MASTERCARD _____ VISA _____