GAILOR ANIMAL HOSPITAL
NEW CLIENT/PATIENT HISTORY

Owner Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone#: _____ Work/Cell Phone #: _____ (circle one)

Employer: _____ Spouse/Alternate Contact: _____

Email Address: _____

If paying by check, please provide your date of birth _____

Driver's License No.: _____ SSN: _____

Signature of Owner/Responsible Agent: _____ Date: _____

Please feel comfortable to request a detailed estimate for services and products for your pet. Should you have any questions regarding your invoice, charges or method of payment, please consult any staff member at any time. All fees are due upon services rendered, or upon hospital release.

Patient Name: _____

Breed: _____ Sex: _____ (Spayed/Neutered) Y/N: _____

Species: ❑ Dog ❑ Cat Date of Birth or Pets Age: _____ Color: _____

What brand and type of food does this pet eat? _____

Is this an inside or outside pet? _____

Is this pet on year-round heartworm prevention? _____ Flea Prevention? _____

Is your pet on any medication? _____

Does your pet have microchip identification? _____ Microchip ID#: _____

FOR OFFICE USE ONLY	
PROBLEM/DATE	**MEDICATIONS**