O L D W I C K A N I M A L H O S P I T A L

Janisse Cailles VMD ~ Anna Owren Fayne VMD ~ Kerry E Scholz DVM ~ Leighann Diehl DVM

Thank you for choosing Oldwick Animal Hospital! We are pleased to welcome you to our practice. Please take a few minutes to fully complete this form so we may better serve you. We look forward to a long and rewarding relationship with you and your pet.

Owner's Information

Name _____ Cell (____) _____-_____

Spouse/Partner Name _____ Cell (____) _____-_____

Home Phone (____) _____-_____ Work/Alternate Phone (____) _____-_____

Mailing Address _____

City _____ State _____ Zip _____

E-mail Address _____

Employer (optional) _____

Emergency Contact _____ Phone (____) ____-_____

Please list anyone else (spouse, partner, etc.) to whom we have permission to provide information about your pet's health status, and/or allow the dispensing of medications/health care products to that party, and/or has your permission to act as this pet's agent for approval of medical procedures in the form of a signature release (multiple names can be provided if applicable).

_____

_____

- We encourage you to download our app, which will directly connect you to our hospital, your pet's reminders, and any upcoming appointments. It is an easy way to communicate with us! (Find the download button on our website: www.oldwickanimalhospital.com)
- Reminders for vaccines will be sent to you through our app, by text, or by email. If these options are unavailable, a postcard will be mailed.
- Appointment Reminders will be sent through our app, by text, or by email. If you cannot receive texts or emails, we will call you.

How did you learn about our hospital? _____
Referred By: _____
(We would like to know who to thank!)

O L D W I C K A N I M A L H O S P I T A L

Janisse Cailles VMD ~ Anna Owren Fayne VMD ~ Kerry E Scholz DVM ~ Leighann Diehl DVM

Pet's Information **Last Name:** _____

Pet's Name _____

Species (dog, cat, rabbit, etc.) _____

Breed _____

Male/Female Neutered/Spayed Age at time of Neuter/Spay? _____

Color _____ Distinctive markings _____

Date of Birth, if known _____ or Age _____

Does your pet have a microchip? _____

If so, please fill in the number (if known) _____

If microchip is in place, is your pet registered with a search service? Y / N

If so, which service _____

Where did you acquire this pet? (shelter, breeder, friend, etc.)_____

How old was the pet at that time? _____

Do you have other pets in the household? _____

Do those pets interact? _____ Happily? _____

What diet is your pet currently on? _____

Do you travel with your pet to any of the following regions/places:

NJ shore? Southern states? Internationally? (Please circle if applicable)

Brief medical history:

Are there any prior illnesses we should know about? Y / N

If yes, what are they? _____

Is your pet currently on any prescription medication other than flea/tick products and/or heartworm preventative? _____

Does your pet have any drug, food or proven contact allergies? _____

Are there any behavior problems, past or current? _____

Are there any household or family circumstances that you want the doctor or staff to be aware of that could alter the medical recommendations made for your pet(s)'s care? _____
(This can also be discussed privately with any of our doctors).

Please request additional pet information sheets for additional patients.

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Dr. Cailles has made many decisions during the design and construction of this building to make it as easily accessible as possible for all individuals wishing to enter.

If you are in need of any assistance either for yourself or your pet, please let us know when making the appointment and/or by calling us on your cell phone from the parking lot.

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As the person responsible for the pet(s) on this file, I understand that all payment is due at the time of service.

Signature of person responsible for pets:

_____ **Date** _____

_____
Printed Name