

**Welcome to the
Animal Medical Center
Of Marquette
(906) 226-7400
www.amcmqt.com**

Client Information

Date: _____ Social Security # _____ Birthday: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Employer: _____

Work Phone: (____) _____ Employer's Address: _____

Emergency Contact: _____ Phone: (____) _____

E-mail Address: _____

How did you learn about our practice?: _____

Primary reason for visit: _____

Pet Information

Pet's Name: _____ Dog Cat Other _____

Sex: M F Age: _____ Birth date: _____ Breed: _____

Color: _____ Neutered/Spayed: Yes No At what age?: _____

What age was your pet obtained?: _____

From: Friend Breeder Pet Shop Humane Society Other _____

Describe your pet's diet: _____

List your pet's current medications: _____

Please check any symptoms or problems you've noticed with your pet:

- | | | |
|---|--|---|
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Gagging | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Behavioral Change | <input type="checkbox"/> Gums Bleeding | <input type="checkbox"/> Thirst |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Limping | <input type="checkbox"/> Urination Increase |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Scooting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Eye Disorders: _____ | <input type="checkbox"/> Shaking Head | <input type="checkbox"/> Other: _____ |

Pet's History (check all that the pet has received and list date given):

- | | |
|--|---|
| <input type="checkbox"/> Distemper _____ | <input type="checkbox"/> Feline Leukemia Test _____ |
| <input type="checkbox"/> Parvo virus (Dog) _____ | <input type="checkbox"/> FVRCP (Infectious Disease-Cat) _____ |
| <input type="checkbox"/> Rabies (Dog/Cat) _____ | <input type="checkbox"/> Dental _____ |
| <input type="checkbox"/> Prior Surgery: _____ | |
| <input type="checkbox"/> Prior Illness: _____ | |
| <input type="checkbox"/> Other: _____ | |

Authorization

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the case of the animal. I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Signature of the client responsible for pet(s): _____

Date: _____

CONFIDENTIAL