CLIENT REGISTRATION

Primary Owner Information

Full Name: _____ Spouse/Partner: _____
Home Address: _____ Apt #: _____
City/Town: _____ State: _____ Zip Code: _____

Phone Number (PRIMARY) : _____ Cell Phone: _____
Home Phone: _____ Work Phone: _____ Fax: _____
Email Address: _____
Contact Preference : (Please circle one) E-Mail Home Work Cell Other

*If your pet is hospitalized, would you like to receive text updates? Yes ☐ No ☐

Employer: _____ Occupation: _____
Work Address: _____
City/Town: _____ State: _____ Zip Code: _____

If we are unable to reach you, whom may we contact in case of emergency?

Emergency Contact: _____ Phone: _____
Do you authorize this person to make urgent treatment decisions if you are unavailable?
YES ☐ NO ☐

Patient Information

Name: _____ Species: Canine / Feline Breed: _____
Date of Birth/Age: _____ Color: _____ Gender: Male ☐ Female ☐ Spay/Neuter: Yes ☐ No ☐
Referring Veterinarian/Hospital: _____ Phone: _____

Would you like us to share your pet's medical records with your veterinarian? Yes ☐ No ☐

Reason for Visit and Special Needs or Concerns:
_____
_____
_____

PLEASE READ: In order to give our clients and patients the individual care and attention they may require, our veterinary specialists may devote additional time beyond a scheduled appointment. We ask for your patience and understanding as YOU MAY EXPERIENCE A WAIT due to unanticipated delays. Be assured, your pet will receive the same special attention. Please alert our reception staff immediately if your pet's condition changes while you are waiting to be seen.

Notice to Pet Insurance Owners:
Arizona Canine Orthopedics and Sports Medicine views pet insurance companies as a third party. Our involvement is to provide records, doctor summaries, invoices, and doctor signatures when requested by you or your insurance company. We do not submit claims to insurance companies on your behalf.
Therefore, it is ACOSM's policy to request and expect payment directly from clients at time of service. Please allow 2 weeks after your pet's appointment for us to provide requested documents to you or your insurance company.

PATIENT INFORMATION and MEDICAL HISTORY

Date: _____
Client Name: _____ Pet Name:_____

Current Problem(s) and Medical History

Duration of current problems (e.g., days, weeks, months)?

_____

List any medical problems or procedures that have occurred within the past two years (include any surgery, trauma, etc.):

_____
_____
_____

General Information

How long have you owned your pet? _____
What is your pet's diet? Canned ☐ Dry ☐
Brand: _____

Are all vaccinations current? Yes ☐ No ☐
Has your pet traveled outside the state within the past 6 months? Yes ☐ No ☐
Are there other pets in your household? Yes ☐ No ☐
If yes, describe: _____

Current Medications

Please list (drug/dose/frequency):

_____
_____

Any unusual reactions to medication(s)? Yes ☐ No ☐
If yes, please describe: _____
_____

Changes in Normal Activity and/or Routines

Appetite :	No ☐	Increased ☐	Decreased ☐	
Water Intake:	No ☐	Increased ☐	Decreased ☐	
Weight:	No ☐	Increased ☐	Decreased ☐	
Bowel Movements:	No ☐	Increased ☐	Decreased ☐	Straining ☐
Urinations:	No ☐	Increased ☐	Decreased ☐	Straining ☐
Coughing/Sneezing:	No ☐	Occasional ☐	Frequent ☐	
Vomiting:	No ☐	Occasional ☐	Frequent ☐	
Changes in walking:	No ☐	Yes ☐		
Skin changes:	No ☐	Yes ☐		
Swellings or masses:	No ☐	Yes ☐		

** Please describe any changes marked above or provide additional information on reverse side. **