

**HIGHLAND SQUARE VETERINARY CLINIC**  
**Members of A.V.M.A. & F.V.M.A.**

Office Consultation  
By Appointment

**PERMANENT RECORD**

Please complete the following Patient information: Today's Date \_\_\_\_\_

1. Owner's Name \_\_\_\_\_ Telephone No. \_\_\_\_\_
2. Address \_\_\_\_\_ Zip Code \_\_\_\_\_  
(If P.O. Box, Street Address) \_\_\_\_\_
3. Breed of Animal \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_
4. Call Name \_\_\_\_\_ Color \_\_\_\_\_ Sex \_\_\_\_\_
5. Neutered or Spayed? \_\_\_\_\_ Date Neutered or Spayed \_\_\_\_\_
6. Vaccinations: Dates when given  
Dog: Distemper - Hepatitis - Leptospirosis - Parainfluenza \_\_\_\_\_ Parvo \_\_\_\_\_ Rabies \_\_\_\_\_  
Bordetella \_\_\_\_\_ Fecal \_\_\_\_\_ Heartworm Check \_\_\_\_\_ Coronavirus \_\_\_\_\_  
Cat: Feline Distemper - Rhinotracheitis - Calici \_\_\_\_\_ Pneumonitis \_\_\_\_\_ Rabies \_\_\_\_\_  
Leukemia Tested \_\_\_\_\_ Feline Leukemia Vaccination \_\_\_\_\_ Fecal \_\_\_\_\_
7. Any physical abnormalities, illnesses or operations in the past? \_\_\_\_\_  
Description of illness \_\_\_\_\_  
\_\_\_\_\_
8. Is your pet on any medication? \_\_\_\_\_
9. Reason for today's visit \_\_\_\_\_  
If ill, length of present illness \_\_\_\_\_  
Has animal received prior treatment for present illness? \_\_\_\_\_
10. Do you have other pets at home? \_\_\_\_\_
11. How did you hear about us?  Front Sign  Phone Book  Relative/Friend (Name Please) \_\_\_\_\_  Other
12. Planned method of payment:  Cash  Check  Credit Card: Visa \_\_\_\_\_ Mastercard \_\_\_\_\_

**CHECK INFORMATION FOR OWNER**

Place of employment (Owner) \_\_\_\_\_  
Spouse Name \_\_\_\_\_  
Business Phone (Owner) \_\_\_\_\_  
Owner: Ht. \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_ Eyes \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Hair \_\_\_\_\_  
D.L.# \_\_\_\_\_ S.S. # \_\_\_\_\_

Witnessed by \_\_\_\_\_

**NO CREDIT**  
**DEPOSIT REQUIRED ON HOSPITALIZED ANIMALS**  
**PAYMENT REQUIRED WHEN SERVICES ARE RENDERED**