

Client Last, First Name: _____

Pet Information: Name: _____ Species: _____ Age/Birthday: _____

Breed: _____ Color: _____

Male Female Spayed/neutered: Yes No Previous clinic/veterinarian: _____

Does your pet have any known **allergies to food** and/or **medication**? Yes No If yes, to what food or medication? _____

Has your pet ever had a **vaccine reaction**? Yes No If yes, to which one(s)? _____

List any **surgeries** your pet has had: _____

List any **behavior** problems of which we should be aware: _____

Diet and treats: Kibble Canned Raw Home-cooked Combination Other _____

Is your pet on **heartworm** prevention and/or **flea/tick** prevention? Yes No If so, which brand? _____

List any other **medications** or **supplements** your pet is taking: _____

What percentage of time does your pet spend **outside**? _____

Photo Release: Indicate your acceptance of our use of your pet's photo for educational and/or record-keeping purposes: Yes No

Authorization for Release of Confidential Medical and Vaccination Records

At Pet Pals we take confidentiality of your pet's medical records seriously. Under Indiana law (IC 25-38.1.4-5.5) veterinary medical records will be furnished to other veterinarians if they request for the treatment of a specific animal and under other limited circumstances as outlined by the law. As a client you may also wish to authorize release of records including vaccination history to non-veterinary facilities, such as boarding kennels or groomers by indicating those below.

I have been provided with a copy of the confidentiality laws governing animals and I hereby give Pet Pals Holistic Veterinary Hospital permission to release the information in the medical records as specified below:

Release information to:

Any/As needed

Grooming _____ Phone/Fax _____

Boarding _____ Phone/Fax _____

Other _____ Phone/Fax _____

Duration:

Life of Pet One Time One year Other _____

Owner Signature

Date

Employee Signature