Compassionate Care for Your Pet Family Member

Dr. Mike Hicks, Dr. Sandra Harris & Dr. Andrew Faist
14940 Mueschke Rd
Cypress, TX 77433
Phone: 281-256-3150 Fax: 281-254-7854 E-mail: info@myfairfieldvet.com
myfairfieldvet.com

Client Information

Owner Name ______________________________ **Co-Owner/ Spouse Name** ______________________________
Primary Phone ______________________________ Co-Owner/ Cell Phone ______________________________
CELL PHONE FOR TEXT REMINDERS . same? ________________ **E-mail**______________________________
Home Address ______________________________ City ______________ State_____ Zip ________
How did you hear about us? ☐I am currently a client ☐Internet Search ☐Sign ☐Fairfield Gazette ☐Yelp ☐Facebook
☐ Who can we thank for referring you?: __________________ Previous Veterinarian/Clinic ____________________

Patient Information

Patient Name __________________________ Species ☐Dog ☐Cat ☐Other ____________________
Sex ☐Female ☐Spayed ☐Male ☐Neutered Breed__________________Color ______________
How long have you owned pet? ________________
Where did you acquire pet? ____________________ Birthday ________________Age________________
Currently on heartworm prevention? ☐Yes ☐No If yes what type/brand? ______________________________
Vaccinations current? ☐ Yes ☐No Reason for visit (primary complaint) ______________________________
What is your pet's diet (Adult/ Puppy/Mature)(Brand)? ______________________________
Does your pet have any **drug allergies** or **medical problems** that we should know about? ____________________
____
Please list any medications your pet is on ______________________________
Any other pets at home? If yes, please list ______________________________
Please check any **symptoms** or **medical problems** that you have noticed about your pet

☐ Behavior Problems	☐ Lack of Appetite	☐ Sneezing
☐ Bleeding Gums	☐ Limping	☐ Increased / Decreased Thirst
☐ Breathing Problems	☐ Loss of Balance	☐Increased Urination
☐ Coughing	☐ Scooting	☐ Vomiting
☐ Diarrhea	☐ Scratching	☐ Weakness
☐ Eye Bulging or Bloodshot	☐ Seems Depressed	☐ Other ______________

IS YOUR PET MICROCHIPPED ☐ YES ☐ NO

WOULD YOU LIKE TO HAVE A MICROCHIP TODAY ☐ YES ☐ NO

How do you plan to pay today (please circle) **Cash Credit Debit Care Credit**

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner ______________________________ Date________________