Welcome To
Animal Medical Center of Cumming, Inc.

New Client Information

Thank you for the opportunity to care for your pet. So that we may become better acquainted and better serve you, please complete the following information.

Name: _____ Spouse's Name: _____

(Domestic Partner or Roommate)

Address: _____ County: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Spouse's Cell: _____

Place of Employment: _____ Work Phone: _____

E-mail Address: _____

How did you hear about us: _____

I acknowledge that I am the owner or acting upon direct request of the owner of the pet(s) brought into this facility. I accept all financial responsibility for any and all care rendered while at this facility and understand that payment is due in full at the time that services are rendered. This constitutes the entire agreement of the parties and no changes will be valid unless received, in writing, and signed by both parties.

Signature: _____ Date: _____

We accept the following forms of payment: Cash, Check, Visa, MasterCard, Debit & Care Credit. There will be a $30.00 fee for all returned checks.

Patient Information

Pet's Name: _____ ☐ Male ☐ Female Spayed/Neutered? ☐ Yes ☐ No

☐ Dog ☐ Cat ☐ Other Breed: _____ Color/Markings: _____

My pet is: ☐ Indoor ☐ Outdoor ☐ Both

Age/Date of Birth: _____ Name of Diet Fed to Pet: _____

Known medical conditions or surgeries: _____

Allergies to vaccines, medicines or supplements: _____

Current medications or supplements: _____

Current brand of heartworm prevention: _____ Last given: ___/___/___

Current brand of flea prevention: _____ Last given: ___/___/___

Previous veterinarian: _____ Phone No: _____

Other pets: _____

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Animal Medical Center of Cumming, Inc.
PET HEALTH CHECKLIST

Name of Pet: _____ Date: _____

Is your pet on any medications or supplements?

_____

What brand of food does your pet eat? _____

If your pet is a cat: Inside Cat _____ Outside Cat _____

Do you have any other pets? Yes _____ No _____

If Yes, what kind? Cat ____ Dog _____ Other _____

Have you ever seen Fleas on your pet? Yes _____ No _____

Have you ever seen Ticks on your pet? Yes _____ No _____

Check if your pet has exhibited any of the following symptoms:

- ❑ Reaction to Vaccines
- ❑ Behavior Problems
- ❑ Bleeding Gums/Bad Breath
- ❑ Blood in Stool or Urine
- ❑ Breathing Problems
- ❑ Broken Bones
- ❑ Car Sickness
- ❑ Chewing Skin Areas
- ❑ Constipation
- ❑ Coughing
- ❑ Depressed/Lethargic
- ❑ Diarrhea
- ❑ Difficulty climbing stairs/jumping
- ❑ Difficulty Hearing
- ❑ Disorientation
- ❑ Dry Heaving
- ❑ Eyes Bulging/Bloodshot
- ❑ Eyes Draining
- ❑ Gagging
- ❑ Hair Loss
- ❑ Hairballs
- ❑ History of Serious Illness
- ❑ Inappropriate Bathroom Habits
- ❑ Increase in Appetite
- ❑ Increase in Thirst/Urination
- ❑ Inflamed/Irritated Skin
- ❑ Lack of Appetite
- ❑ Limping
- ❑ Loss of Balance
- ❑ Odor from Ears
- ❑ Scooting
- ❑ Scratching
- ❑ Seizures
- ❑ Shaking Head
- ❑ Sneezing
- ❑ Thunderstorm Anxiety
- ❑ Vomiting
- ❑ Weakness
- ❑ Weight Gain or Loss
- ❑ Worms in Stool
- ❑ Is your pet the best in the world?

_____

_____

_____