



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: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Place of Employment: _____ Wk Phone: _____ Spouse's Cell _____

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. AMC is legally and ethically obligated to provide care to pets in dire medical need or pain. In the event of serious illness or injury and I am unreachable, I hereby consent to any medically necessary treatment while under the care of Animal Medical Center of Cumming, Inc. 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: _____

**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:

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