Kalona Veterinary Clinic, P.C.
P. O. Box 847 405-6th Street
Kalona, IA 52247
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Patient and Client Information Sheet

Date

Thank you for giving us the opportunity to care for your pet! So that we may become better acquainted, would you complete the following?

We appreciate knowing how you become aware of our clinic:

___ Clinic Sign ___ Location ___ Web site ___ Yellow pages ___ Other

___ Personal recommendation - Who may we thank? _____

Owner/Caretaker: Mr. Mrs. Dr. Ms. _____Cell: _____

Co-owner/ Caretaker: Mr. Mrs. Dr. Ms. _____ Cell: _____

Children _____

PO Box _____ Address _____

City _____ Zip _____ Residence Phone _____

KVC, P.C. may use my e-mail address _____ only for reminders, newsletters, and office communications. (We do not give out e-mail addresses to third parties, other than our reminder system).

Place of employment of owner _____ Phone _____

Place of employment of co-owner _____ Phone _____

If necessary, may we call you at work? Yes No Best time to call _____

When is the best time to reach you _____

So that we are able to suit your individual needs, which do you feel most applies to you:

Check One.
(1) ___ I feel that my pet is another member of our family.
(2) ___ I feel that my pet is very important to us, but is a pet.
(3) ___ I feel that my pet is just a pet.

Check One.
(1) ___ I want the best medical care available for my pet; please recommend anything that you feel is necessary for good health.
(2) ___ I want good medical care for my pet, but there is a limit to what I am able to have done.
(3) ___ I want you to perform only the services I request.

Check One.
(1) ___ I prefer to be present when my pet is examined and treated.
(2) ___ I would rather not see my pet examined and treated.
(3) ___ I do not have a preference, either is fine with me.

Would you like us to keep you informed about procedures that may lengthen the life of your pet? Yes No

My Pets:

Dog /Cat	Name	Sex	Altered	Birth date or Age	Breed
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____

Do your pets have any known allergies? _____

What prior illnesses or surgeries should we know about? _____

Is your pet currently on a special diet or medication? _____

Are any of the following a concern to you about your pet(s)?

_____ Excessive Barking _____ Biting _____ Shedding _____ Straying ____ Smell

_____ Soiling in the house _____ Separation /Storm anxiety _____ Excessive itching/scratching

_____ Overly rambunctious/enthusiastic _____ Problems around children _____ Weight

For your convenience we can provide reminders for when vaccinations or procedures are needed. If you are transferring the care of your pets to our office, we can create reminders for you. If you would like us to acquire copies of your records, please sign below.

I give permission to transfer my pets' records from _____
(to the Kalona Veterinary Clinic, P.C.)

************ REQUIRED – PLEASE COMPLETE THE FOLLOWING ****************

We accept MasterCard / Visa, Discover, Cash or Check, and Debit Cards. Unless prior arrangements have been made, accounts must be paid in full at the time that services are rendered. For certain procedures, we may request that some amount be paid before the procedures are completed. If you would like a written estimate, we would be glad to provide one for you.

The person(s) responsible for paying this account is/are _____.

My preferred method of payment is _____.

I understand that payment must be complete before taking my pet home. (Signed) _____

Thank you for taking the time to complete this information.