Date: [Insert Date]

Client and Patient Reference Information

Client Information

Full Name: [First Name] [Last Name]

Address: [Street Address, City, State, Zip Code]

Phone Number: [Phone Number]

Email Address: [Email Address]

Emergency Contact: [Name and Phone Number]

Patient (Pet) Information

Pet Name: [Pet Name]

Species: [e.g., Dog, Cat, Bird]

Breed: [Breed Type]

Gender: [Male/Female] - [Spayed/Neutered: Yes/No]

Date of Birth / Age: [DOB or Estimated Age]

Color/Markings: [Description]

Microchip Number: [Number if applicable]

Medical History Summary

Current Medications: [List Medications and Dosage]

Allergies: [List Allergies]

Existing Conditions: [List Medical Conditions]

Last Vaccination Date: [Date]

Authorized Signature: _____

Printed Name: [Name of Person Completing Form]