PATIENT INFORMATION AND CONSENTMENT FORM

Owner´s Name:________________________________ Date: ________________________________

Best Phone Number to contact: ______________________ Alternate Phone Number: ______________________

Pet Name: __________________________ Age: ___________________ ☐ Canine or ☐ Feline

Intact Male / Neutered Male / Intact Female / Spayed Female

Breed: ____________________________ Colors/ Markings: __________________ Aproximate Weight:________

Is your pet on any medications? ☐ Yes ☐ No If wes, what? ____________________________________

Has your pet had any allergic reaction to a vaccine, insect bite or any medication, in the past? ☐ Yes ☐ No

If yes, when? ____________________________ What ocurred? _________________________

In the past month, has your pet had any: coughing, sneezing, discharge, diarrhea, not eating, vomiting? ☐ Yes ☐ No

If yes, circle Symptom. Please describe:____

Does your pet have fleas, ticks, or mites? ☐ Yes ☐ No If yes, have they been treated/when? _______________

My pet is here for: ____

I understand that my dog will be evaluated and treated for non anesthetic dental scaling and all my questions were answered and explained correctly.