

DENTAL - PRE-EXAMINATION HISTORY AND CONSENT FORM

Please complete the information below so we can keep our records up to date.

Owner's Name: _____ Pet's Name: _____ Today's Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Which phone number should we use to contact you today? Home Cell Work Other: _____

If appropriate, would you prefer us to contact you via text message? Yes [Valid cell number] No

Email Address: _____ [Please inform a receptionist if your mailing address has changed]

Do you have Pet Insurance? Yes No If "Yes", which provider is your policy with? _____

Reason(s) for today's visit: _____

What brand of food do you feed your pet? _____ How much? _____ How often? _____

Has your pet eaten today? Yes No [If "Yes"] What? _____ What time? _____

Does your pet take any medications and/or nutritional supplements? Yes No

[If "Yes"] What kind and please write when it was given last?

Does your pet have any allergies? Yes No [If "Yes"] What kind? _____

Do you use a flea/tick preventative? Yes No [If "Yes"] What kind? _____

Does your pet have a microchip? Yes No [If "No"] Would you like one implanted today? Yes No
(Cost of a Microchip Implant is \$73.19)

Dog: Is your dog given heartworm preventative year-round? Yes No [If "Yes"] What Kind? _____

[If "Yes"] Date last administered? _____

Will your dog be boarding in a kennel within the next year? Yes No

Does your dog do any of the following? (Check all that apply): Hunt Run/hike in the woods?
 Have exposure to livestock urine? Groom them self? Come in contact with other dogs?

Cat: Does your cat go outside? Yes No

Has your cat ever been tested for leukemia or feline aids? Yes No
[If "No"] would you like your cat to be tested today? Yes No

Has your cat ever been tested for heartworm disease? Yes No

Is your cat on monthly heartworm prevention? Yes No

Dog or Cat: Has your pet exhibited any of the following signs, symptoms or behaviors? (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Coughing | <input type="checkbox"/> Unusual discharge |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Body odors |
| <input type="checkbox"/> Appetite increase | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Scooting rear end |
| <input type="checkbox"/> Appetite decrease | <input type="checkbox"/> Gagging | <input type="checkbox"/> Head tilt |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Choking | <input type="checkbox"/> Ear scratching/rubbing |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty climbing stairs | <input type="checkbox"/> Increase in grooming behavior |
| <input type="checkbox"/> Constipation/difficult defecation | <input type="checkbox"/> Uncoordinated | <input type="checkbox"/> Decrease in grooming behavior |
| <input type="checkbox"/> Increased drinking | <input type="checkbox"/> Lameness | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Decreased drinking | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Scratching |
| <input type="checkbox"/> Soiling/Incontinence/dribbling stool or urine | <input type="checkbox"/> Decreased activity | <input type="checkbox"/> Poor coat |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Listlessness | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Weakness | <input type="checkbox"/> Behavior change |
| <input type="checkbox"/> Drooling | <input type="checkbox"/> Muscle tremors | <input type="checkbox"/> Skin problems |
| | <input type="checkbox"/> Shaking | |
| | <input type="checkbox"/> Seizures | |

Lumps or bumps? (Please note location on diagrams on back of this page)

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