

CELL PHONE NUMBER TODAY: () -

Ok to text to this number? YES NO



CANINE WELLNESS / EXAM AUTHORIZATION and MEDICAL RECORD

Owner name: _____ Date: ____ / ____ / ____

Address: _____

City: _____ State: ____ Zip: _____ County: _____

Phone #: (____) _____ E-mail: _____

Dog's name: _____ Color: _____ DOB/Age: _____ Breed: _____ M/F: ____

___ Visit Fee \$25 ___ Tech Fee \$15

Parasite Control:

___ Heartworm Prevention / Dewormer*

___ Flea/Tick Control*

* Price, type of product and availability varies.

___ Microchip \$30.00

___ Nail Trim \$15

___ Anal Glands Expression \$18

___ Ear Clean \$15

Organization Admin fee: \$ _____

Vaccination:

___ Rabies: 1-yr / 3yr \$10.00

___ DHLPP: Series / 1-yr / 3-yr \$16.00

___ DHPP Only: Series / 1-yr / 3-yr

___ Lepto Only: Series / 1-yr

___ Bordetella: 1-yr \$15.00

___ Lyme Vaccine: Series / 1-yr \$35.00

___ Influenza Vaccine: Series / 1-yr \$45.00

*****3-yr Rabies requires proof of previous vaccination
by a licensed veterinarian at time of intake*****

Labwork:

___ Junior Wellness Profile \$115.00

___ Senior Wellness Profile \$160.00

___ Heartworm/Lyme/Anaplasma/Ehrlichia \$35.00

___ Fecal Exam \$40 ___ Diarrhea Panel: \$110

Additional Services requested: _____

I, the undersigned, certify that I am the owner, or authorized agent, of the animal described above. I authorize the doctor on duty and assistants to perform the services listed above, including the administration of pain relief medications, sedatives, and anesthetics. I understand that, although rare, there are risks with any medical treatment, sedation and anesthetic procedure including drug/vaccine reactions, infection and death. I also understand that no guarantee of successful treatment can be made.

Signature of owner/agent: _____

For Clinic Use Only (do not write below this line)

Exam findings: Wt.(lbs.): ____ T ____ P ____ R ____ BCS ____/9 Dental ____/4

Laboratory tests: _____

Prescriptions: _____

Recommendations: _____

Microchip # _____

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PATIENT HISTORY

Please fill in all information as completely as possible to allow optimal care for your dog

Owners Name: _____ Patient's Name: _____

Telephone number where we can reach you today: () _____

How long have you owned this dog? _____

Where did you obtain this dog?

Rescue Breeder Online Pet Store Stray Friend/Relative My dog's litter

Is your dog (circle one): Indoor only Outdoor Only Indoor/Outdoor

Has your dog displayed any of the following in the last 2 weeks: (check if yes)

Sneezing Coughing Vomiting Diarrhea

Has your dog ever had a seizure? No Yes, explain: _____

Has your dog had **any** previous...:

...Illness, Injury or Previous Surgery? No Yes, please explain: _____

...Drug or vaccine **reaction**? No Yes, please explain: _____

Is your dog on any long-term medications? If so, list all _____

Has your dog been given any medications in the last 30 days? If so, list type and why it was given

Has your dog been treated for fleas/ticks? No Yes, what product was used? _____

Is your dog on monthly heartworm prevention? Yes No

If yes, what type? Heartguard. Interceptor Revolution Other: _____

When did your dog last eat? _____

How did you hear about the Rascal Unit? _____

Do you have a regular veterinarian? Yes No

IF your dog is female: When was her last heat cycle? _____ Unsure Spayed

Has she had any litters? No. Yes, When? _____

Could your dog pregnant? Yes No