



Garden City Veterinary Hospital

*Welcome! Thank you for giving us the opportunity to care for your pet.
Remember to bring any pertinent medical history or records.*

Owner Information

Name _____ Co-Owner: _____

Address _____

City _____ Zip _____

Preferred Phone(_____) _____ Alternate

Phone(_____) _____

Driver's License _____ (if paying by check or credit card)

Email _____

If referred, by whom? _____

Patient Information

Pet's Name _____ Dog Cat Other

Male Female Is your pet spayed/neutered? Yes No

Breed _____ Birth date or Age _____

Reason for today's visit: _____

Please list any current or chronic health problems, medications, or prescription diets: _____

Is your pet allergic to any medications or vaccines?

Do you have pet insurance? _____ Is your pet micro-chipped? _____

What other pets do you have? Dog(s) Cat(s) Other
