Welcome!

8094 Morgan Circle, Bloomington, MN 55431

Special Care For Special Friends

Best Friends Animal Hospital

Please Complete this Questionnaire for Our Records.

Your Name: _____

Spouse/Partner/Co-owner Name: _____

Home Address: _____

City, State, Zip: _____

Phone: (H) _____ (C) _____ (W) _____

Would you like to receive E-mail Reminders for future visits? ☐ YES ☐ NO

E-mail Address: _____

How did you hear about us? ☐ Internet ☐ Yellow Pages ☐ Friend, who:_____
☐ Other _____

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1. Pet's Name: _____ Sex: M or F Neutered or Spayed (circle correct answers)

Breed: _____ Date of Birth: _____

Color: _____ Allergies?: _____

Current Diet: _____

2. Pet's Name: _____ Sex: M or F Neutered or Spayed (circle correct answers)

Breed: _____ Date of Birth: _____

Color: _____ Allergies?: _____

Current Diet: _____

****If under 18 years of age we must have the parent or guardian's authorization.****

Upon your request we will provide you with a written estimate of fees for any case where hospital treatment, emergency care, surgery or hospitalization will be provided. A deposit prior to treatment may be required.
We accept CASH, CHECKS, VISA, MASTERCARD, DISCOVER and Care Credit.

I am the owner or authorized agent of the above described animal(s) and am responsible for payment in full at the time the animal(s) are discharged, unless other arrangements are made in advance.

Signature of the Owner or Agent: _____ Date:_____

FLIP OVER – SEE OTHER SIDE

Wellness Exam Checklist

In order to better tailor our services to your pet, please fill out this information.

Pet's name(s):_____

Does your pet currently, within the last year:

- ❑ Eat people food?
- ❑ Eat non-food items? (example: socks, towels, string, tinsel)
- ❑ Have any known allergies?
- ❑ Easily take medications? Tablets or Liquids?
- ❑ Live mostly outdoors?
- ❑ Live mostly indoors?
- ❑ Had seizures? How often? _____
- ❑ Associate with children age 15 and under? This includes neighbors and relatives.
- ❑ Associate with people with immune deficiencies?
- ❑ Travel to other states? If yes, which other states/countries?
- ❑ Live with other animals? What kind and homw many? _____

Does your DOG…

- ❑ Go to dog parks?
- ❑ Go to groomers?
- ❑ Go to boarding kennels or pet daycares?
- ❑ Go on Humane Society or group animal walks?
- ❑ Attend agility or flyball events?
- ❑ Attend pet classes?
- ❑ Go hunting?
- ❑ Swim or play in lakes or rivers?

Does your CAT…

- ❑ Share a litter pan with other cats?
- ❑ Has your cat been tested for feline leukemia?
- ❑ Do you trim your cat's toenails?
- ❑ Use its litter box consistently?

Comments/Details:_____
_____

- ❑ I give permission for my pet's medical information to be given to groomers and/or boarding facility upon request.
- ❑ I give permission for my pet's vaccine information to be given to City Animal Control agencies upon the city's request.
- ❑ I give permission to fax/mail/verbally transfer my pet's records to other veterinary clinics or hospitals upon their request.
- ❑ I give permission to transfer my pet records to: _____
- ❑ I give permission for other family members to receive my pet's information upon request.

This permission allows smooth information movement when needed. This signature form will be held for the life of all your pets listed above. If there are changes in the above authorization, a replacement form must be completed for our records.

Signature:_____Date_____