



Fox Valley
Veterinary
Dentistry & Surgery

New Client Information Form

Thank you for trusting your family doctor's referral to us for your pet's oral healthcare.
Please fill out the following information to allow us to complete your pet's medical record.

Owner's Name _____	Date _____
Co-Owner's Name _____	
Address _____	City _____ Zip Code _____
Home Phone _____	Work Phone _____ Cell Phone _____
Co-owner's Work Phone _____	Cell Phone _____
Patient's Name _____	Birthdate _____ Weight _____
Breed _____	Sex Male <input type="checkbox"/> Female <input type="checkbox"/> Neutered <input type="checkbox"/> Spayed <input type="checkbox"/>
Family Veterinarian _____	Hospital _____
Problem that prompted referral of your pet: _____	
Pertinent Medical History _____	
Present Medications _____	
Do you brush your pet's teeth? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, how often? _____	
Chew toys? _____	Diet? _____

I assume responsibility for all charges incurred in the care of this pet. I understand that full payment, in the form of cash, check, Visa or MasterCard is expected when services are rendered.

I understand that my family veterinarian has referred my pet to Fox Valley Veterinary Dentistry and Surgery, with locations at Gateway Veterinary Clinic and Animal Medical Center of Chicago for oral healthcare. I agree to return to my family veterinarian for all other healthcare needs for my pet and furthermore agree that I will not return to Gateway Veterinary Clinic or Animal Medical Center of Chicago for any healthcare needs for my pet.

Signed _____ Date _____

p: 847.525.8642

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www.fvuds.com

St. Charles & Chicago