ANIMAL SURGICAL
& ORTHOPEDIC CENTER
A BETTER WAY TO OPERATE + SINCE 1986

CLIENT INFORMATION

Your Name_____ Today's Date_____

Secondary Owner_____

Address_____ City_____ State____ Zip Code_____

Your Contact Phone Numbers (in order of preference)

1. ( ) _____ Cell Work Home Name/Relationship_____

2. ( ) _____ Cell Work Home Name/Relationship_____

3. ( ) _____ Cell Work Home Name/Relationship_____

Occupation_____ Email Address_____

PET INFORMATION

Pet's Name_____ Pet's Weight Today _____

☐ Canine ☐ Feline Age or Date of Birth_____

Breed_____ Color_____

☐ Male Intact ☐ Male Neutered ☐ Female Intact ☐ Female Spayed

Does your pet have a history of seizures? ☐ Yes ☐ No

Has your pet had any adverse reaction to anesthesia or medication? If so, please describe.

_____

Please list any medication or supplements that your pet is taking now or has taken within the past 2 weeks.

_____

Referring Veterinarian and Hospital Name_____

Regular Veterinarian and Hospital Name (if different from above)_____

How did you hear about our clinic? (check all that apply)

☐ My Veterinarian ☐ Animal Medical Center of Seattle ☐ Friend/Family Member

☐ Yelp ☐ Google/Search Engine ☐ Facebook ☐ Other Online Source: _____

☐ Community Event_____ ☐ Other_____

We often take pictures of our hospitalized patients and post stories on our website, Facebook or Instagram.
Do you authorize use of pictures of your pet for this purpose only? ☐ Yes ☐ No

Signature _____

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