

ACR# _____



Animal Clinic of Rockford

MICROCHIP: YES NO - Num. Below

815-636-7297

Please Fill Out Completely –

Owner's Name: _____

Pets Name: _____

Dog Cat Other

Street Address: _____

Breed: _____

Zip Code & County: _____

Colors: _____

Phone No 1: _____

Age Estimate
Date of Birth (If Known)

Phone No 2:

Male Female

Cell Provider
(Appt Reminders): _____

Neutered Spayed

E-mail
(Annual Reminders): _____

VACCINATIONS ARE MEDICALLY REQUIRED TO BE IN HOSPITAL

ARE PET'S SHOTS (RABIES AND DISTEMPER/PARVO)
UP TO DATE?

YES NO

WHEN AND WHERE
WERE THEY LAST DONE? _____

HOW DID YOU HEAR ABOUT US? IF FRIEND / FAMILY WHO RECOMMENDED YOU?

Known Medical Conditions: _____

Other Pets in Household – Number & Species: _____

ARE YOUR PETS INDOOR / OUTDOOR OR BOTH? _____

HAS YOUR PET BITTEN ANYONE IN THE LAST 10 DAYS? YES OR NO

DO YOU GO CAMPING / OTHER OUTDOOR ACTIVITIES WITH YOUR PET? YES OR NO

We like to have 'family photos' in our pet medical file; these are kept within the clinic unless you consent – are you alright with occasional cute photos to be shared on our Facebook page? YES OR NO

BEHAVIOR ISSUES THAT CONCERN YOU? _____

REASON FOR YOUR CURRENT VISIT? _____

***CLINIC REMINDERS AND CONFIRMATIONS ARE EASILY DONE VIA E-MAIL & TEXT MESSAGING – PLEASE BE SURE THE FORM IS COMPLETE SO WE CAN HELP KEEP YOUR PET AS HEALTHY AS POSSIBLE. ***

AFTER READING HOSPITAL RELEASE FORM POSTED IN LOBBY & ROOMS, PLEASE SIGN HERE:

X _____