



Client and Patient Information Form

*For Pet Owners

Client Information

Name _____

Email _____

Street Address _____

City _____ Postal Code _____

Home Phone _____ Mobile Phone _____

Work Phone _____

Alternate Contact Name _____ Contact Phone _____

Referring Veterinary Practice Name _____

Practice Phone number _____

Veterinarian's name _____

Patient Information * all fields are important to complete

Pet's name _____ Species Canine Feline

Gender Male Male/Neutered Female Female/Spayed

Birth Date _____ Breed _____ Colour _____

Tell us the reason(s) your pet is being referred to a dentist _____

Current Vaccine history (must be up to date on Rabies) _____

Current diet _____

Date of last dentistry _____

List current medical conditions _____

List all current medications _____

List all supplements or over the counter medications _____

Pet insurance company and policy number _____

I give Bayview Wellington Veterinary Clinic permission to photograph my pet for the purpose of documenting the treatment and I understand that the photographs may be used for educational and promotional purposes which includes social media. Confidentiality is assured.

I have read and understand the Bayview Wellington Veterinary Clinic's Personal Information Policy

Client Signature _____