987 Laurel St., San Carlos, CA 94070
Phone: (650) 610-9501
Fax: (650) 610-8970
animaldentalclinic.com
staff@animaldentalclinic.com

Owner's last name	First name

Pet's name	Age or birthdate	Species	Breed
		☐Dog ☐Cat ☐Other	

Sex	Color	Reason for visit
☐Female ☐Spayed ☐Male ☐Neutered		

Does your pet show signs of pain or any behavior change? If yes, please describe, and include when this was first noticed.

Does your pet have any history of dental problems or previous dental treatment?

Does your pet have any history of major or chronic medical problems, surgery, or hospitalization?

Please list your pet's medications, including supplements, topical (ear, eye, and skin) medications, and flea/heartworm preventatives.

Does your pet have any allergies (food, medication, other)? If yes, please list.

Does your pet receive dental homecare (ex: toothbrushing/rinses/chews)? If yes, please describe, and note how often.

Diet:		Amount per feeding?	Feedings per day?
	☐Dry ☐Can ☐Other		

Toys and treats:

☐Rubber chew ☐Plush toy ☐Tennis ball ☐Frisbee ☐Rope toy ☐Dental chew ☐Ice cube ☐Biscuit ☐Soft treat ☐Pig ear ☐Bone/antler/hoof ☐Rawhide/bully stick ☐Nylon bone ☐Other:

What other pets do you have at home?

Are there any additional questions, concerns, or topics that you would like to discuss with our doctors or staff?

Patient vital statistics (to be completed by Animal Dental Clinic staff)

Weight	RR	HR	CRT	MM color	Temperature	BCS	
lb	/min	/min	sec		°F	/9	

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New Patient Registration

Owner's last name	First name	Additional contact	
			☐Spouse/partner ☐Relative ☐Friend/Pet sitter
Address		**Home phone**	**Work phone**
City	**Zip**	**Mobile phone**	**Other phone (please specify)**
Email			
			May we include photos of your pet (without your name) on our clinic's website or social media accounts? ☐Yes ☐No
How did you learn about our Animal Dental Clinic?			
☐Veterinarian ☐Friend/relative ☐Location ☐Website ☐Yelp ☐Other			
If other, please specify:		**Who may we thank for your referral?**	
Primary veterinarian		**Referring veterinarian (if other than primary)**	
Hospital name		**Hospital name**	
Name of pet(s)			

I confirm that I am the owner of the pet(s) listed above, that I am at least 18 years old, and authorized to make decisions regarding pet care. I authorize the staff of Animal Dental Clinic to examine, prescribe medication for, perform diagnostic and/or surgical procedures, and otherwise treat the above pet(s) as the doctors of Animal Dental Clinic deem to be in my pet's best interest. I understand that in all but dire emergencies, all treatments and procedures will be discussed with me prior to action. I assume responsibility for all charges incurred in the care of this pet (as well as collection costs, if required), that these charges for treatment will be paid at the time of discharge, and that a deposit may be required prior to treatment.

I acknowledge that I have read, understand, and agree with the above.

Signature	Date

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