Pet Wellness Center, LLC

NEW PATIENT INTAKE FORM
PLEASE PRINT LEGIBLY

If you arrive without completed paperwork, the time taken to fill out the forms will take away from doctor time.

Date: _____
Name of Human Caretaker: _____
Name of Human Caretaker Spouse/Partner:_____
Home & Mailing Address (if different): _____
City/State/Zip: _____
Main Phone Number: _____ **Secondary Number:** _____
Email Address: _____
How did you learn about The Pet Wellness Center? _____

When & Where did you get your pet? _____

Pet's Name: _____ **Species:**_____ **Breed:** _____

Color: _____**Approximate Weight:** _____

Age/Birthdate: _____**Sex:** _____ **Spayed/Neutered:** _____

Age at time of surgery:_____ **If intact, has pet had any litters:** _____

Pet's purpose: (circle all true) Family | Service | Working | Show | Pet | Other

Have there been any recent changes in:
Weight: _____ Mood: _____
Thirst: _____ Appetite: _____
Urination: _____ Defecation: _____

Is your pet aggressive toward: (circle all true)
Dogs | Cats | Animals | Men | Women | Kids

Specify the problem and your goals for today's visit: _____
_____

When did it start? Does anything make it better?:_____
_____

Has your pet been seen by another vet for this issue? Yes | No
If Yes, Clinic Name:_____Phone number: _____
Please provide name & number of any other Veterinarian & clinics that have seen your pet:_____
_____

Flea control, type & frequency: _____**Date last given:**_____

***Heartworm Prevention, type & frequency*:**_____ **Date last given:**_____

What type of *food* does your pet get? Kibble | Canned | Dehydrated | Home cooked | Raw |Other

Food Brand Name: _____

Supplements (Please include the *brand, product, how much, how often* you give it to your pet):

_____

_____

Treats? _____

List all medications and dosages:

Medication: _____ **Dosage:** _____
Medication: _____**Dosage:** _____
Medication: _____**Dosage:** _____
Medication: _____**Dosage:** _____
Medication: _____**Dosage:** _____

Exercise type & frequency: _____

Has your pet traveled/lived outside of this area? (List where, when, & for how long)

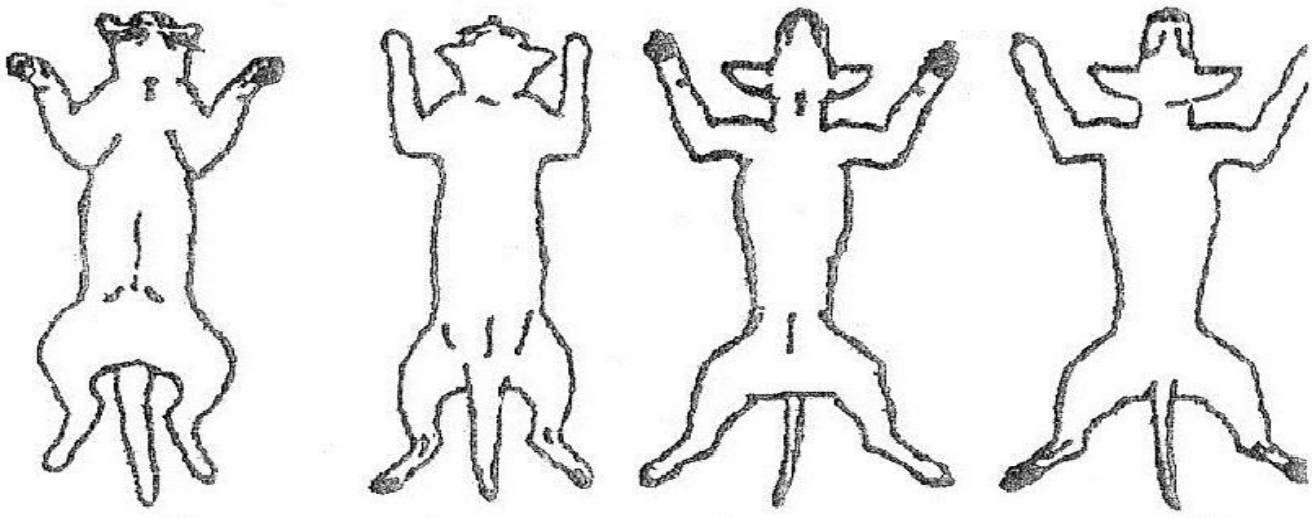
_____

Does your pet have any inherited conditions?
Hip dysplasia | cancer | diabetes | congenital heart defects

Any known allergies?: _____

Date of last dental cleaning?: _____

Please shade in the areas on the chart where you are noticing lameness or soreness. Please place circles/dots where there are lumps/masses.



Please give us a chronological list of all symptoms

Date:	Symptoms:	Action Taken:

Please initial each paragraph once you have READ, UNDERSTOOD, AND AGREED to the terms:

I understand that Dr. Iris Ramirez is a licensed veterinarian whose practice focuses on alternative and holistic therapies, several of which are considered experimental at best and quackery at worst by the FDA and other regulatory agencies, including but not limited to: chiropractic, herbs & herbal supplements, nutrition/food therapy, routine lab work, homeopathy, detoxification, aromatherapy, cold laser therapy, ozone therapy, infrared therapy, and the understanding of the human-animal bond.
(Circle all modalities listed that you are open to or would like to learn more about.) _____ **Initial**

I understand that The Pet Wellness Center, LLC currently does not offer surgery, anesthetic dentistry, or radiographs and can provide a referral if these are needed or desired. I understand that alternative care is not a substitute but is a complement to routine veterinary care, including dental care. **I understand that my own participation is essential in helping my pet.** This includes but is not limited to providing appropriate social, psychological, hygienic, physical, emotional, spiritual, mental, and routine medical care for my pet, as well as myself. I understand and am open to learning more about how my own energy affects that of my pet. _____ **Initial**

I understand that Dr. Ramirez always does her utmost best to heal patients and there is never a guarantee as to the outcome; as is true with all medicine and all aspects of life. _____ **Initial**

I understand that if my pet is to receive long term herbs and/or supplements, a current doctor/patient relationship must be maintained by scheduling an exam at least once a year if patient is younger than 7 years of age, or at least once every six months if 7 years of age or older.

_____ **Initial**

I give consent to Pet Wellness Center, LLC to take video/pictures of my pet. I give my permission to Pet Wellness Center to upload these videos/pictures to Pet Wellness Center social media sites.

_____ **Initial**

I understand that opened, mixed, or hand-counted supplements, herbs, homeopathic remedies, and medications cannot be refunded. _____ **Initial**

I understand that if my pet's medical history contains extensive amounts of documentation, there will be an additional records review charge for the Dr.'s time spent examining these records. _____ **Initial**

I understand that payment is due at the time of services rendered and that there is a $30 fee for any returned checks.

_____ **Initial**

I UNDERSTAND THAT IF I FAIL TO GIVE 24 HOURS' NOTICE FOR CANCELLING OR RESCHEDULING AN APPOINTMENT OR IF I DO NOT SHOW FOR A SCHEDULED APPOINTMENT, I WILL BE CHARGED A $40 FEE FOR DISREGARD OF THE DOCTOR'S TIME AND THAT OF FELLOW CLIENTS WHO WOULD HAVE LIKED THAT APPOINTMENT TIME SLOT.

_____ **Initial**

IF MULTIPLE NO SHOWS OR CANCELLATIONS/RESCHEDULES WITH LESS THAN 24 HOURS' NOTICE HAVE OCCURRED, THE PET WELLNESS CENTER WILL REQUIRE PRE-PAYMENT FOR FUTURE APPOINTMENTS. NOT SHOWING FOR A PRE-PAID APPOINTMENT WILL RESULT IN FORFEITURE OF PRE-PAID AMOUNT.

_____ **Initial**

Signature:_____ Date:_____

Print Name:_____