



VCA San Francisco Veterinary Specialists Dentistry Intake Form

We appreciate your taking the time to fill out this form. Please answer the prompts as best as possible and **print clearly**.

Today's Date:	Owner/Caregiver:
Pet's Name:	Pet's Age:

What is the reason for your visit today?/What is the main problem your animal is being seen for today?
How long has this problem been present?
How frequently does this problem occur?
What previous treatment for this problem has your animal received?
What was the response?
Please list all medications or supplements your animal is taking:
Any adverse reactions or allergies to medications or anesthesia?
How long have you owned your pet?
Is there any previous illness/injury?
List any other animals in your household:
Is your pet spayed or neutered?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Do you plan to breed your pet?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Has your pet eaten today?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
What is your pet's normal diet (food type and frequency)?
Please list any chew toys or chew treats you give your pet:
Are you able to brush your pet's teeth?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, how often?
What is your pet's attitude at home?: <input type="checkbox"/> Alert <input type="checkbox"/> Depressed <input type="checkbox"/> Unknown
Have there been any attitude changes recently?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown

(Continued)

Appetite:	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Normal	<input type="checkbox"/> Unknown
Water Consumption:	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Normal	<input type="checkbox"/> Unknown
Urination:	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Normal	<input type="checkbox"/> Unknown
Defecation:	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Normal	<input type="checkbox"/> Unknown

Skin Disease?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Vomiting?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Diarrhea?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Difficulty Swallowing?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Difficulty Breathing at Rest?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Coughing?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Sneezing?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Nose or Eye Discharge?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Head/Face Scratching?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Decreased Grooming?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Crying Out When Eating?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tires Easily With Exercise?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Lethargic?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Increased Weakness?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Lame/Limping?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Abnormal Behavior?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Seizures?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Eye Abnormalities?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Weight Loss?:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Vaccination History		Heartworm Prevention History	
D-H-L Para	Date:	Date of Last Heartworm Test, if Known:	
Parvo	Date:	List Heartworm Preventatives Given:	
Rabies	Date:		
FVRCP	Date:		
FelV	Date:		
Other	Date:		

STATEMENT OF OWNERSHIP AND CONSENT: I am the owner and/or agent of the above animal and have the authorization to consent to treatment if and when it is needed. By signing this agreement, I authorize VCA San Francisco Veterinary Specialists staff to provide care and perform any treatment, including the administration of anesthesia and surgical procedures they consider reasonable and necessary for my animal, and I consent to any such services. I understand that with any medical or surgical procedures there are always risks involved, including death, and that no warranty or guarantee is being made as to the results or cure.

I understand that I must come in and collect my animal before close of the next business day once notified to do so. Additional charges will accrue if my animal is not collected on the day he or she is ready to be released from the hospital. I will be responsible for all charges incurred. I understand that all veterinary services are to be paid for at the time such services are provided. A finance charge of 1.5% (18% per annum) will be charged on all unpaid invoices beginning 30 days from the invoice date. All unpaid checks and delinquent accounts will be transferred to a collection agency.

Owner/Authorized Caregiver Signature (Required): _____ Date: _____
 Verified by (Office Use Only): _____