

CLIENT SATISFACTION SURVEY

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent
And 1=Poor

Professionalism Of
Our Staff:

Cleanliness Of Our
Facility:

Quality Of Services
Received:

Overall Impression
Of Our Practice:

Did You Have To
Wait Past Your Yes
Scheduled No
Appointment Time?

If You Answered
"Yes" To The
Previous Question,
Then Please Tell Us
How Long You Had To
Wait For Your
Appointment:

Please Feel Free To
Leave Us Any
Additonal Comments:

Client Name:

Client Phone
Number:

Alternative Phone
Number:

Client E-mail
Address:

Pet's Name:

Name Of Medication
To Be Refilled:

Quantity To Be
Refilled:

Current Dosage
Given:

Any Side Effects Yes
Seen? No

Date Of Pet's Most
Recent Exam:

Additional
Comments:

We Will Contact You After Your Request Has Been Reviewed By A Doctor.
Please Allow 24 To 48 Hours For Processing Of Your Request.

BOARDING REGISTRATION FORM

All Boarders **MUST** Have Up-To-Date Vaccinations!

Drop-Off Date

Requested:

Pick-Up Date

Requested:

Owner's Name:

Owner's Phone
Number

Street 1:

Street 2:

Owner's Address:

City:

State:

Zip:

Pet's Name:

Emergency Contact
Name:

Emergency Contact
Phone Number:

Would you like your
pet bathed?

Yes
No

List your pet's
belongings:

How many times
should we feed your
pet per day?

AM

Feed my pet in the:

PM

Both

Will your pet
receive his/her
medications prior
to arrival for
boarding?

yes
no

Will you feed your
pet prior to
arrival for
boarding?

yes
no
N/A

Please list any special instructions (include detailed medication directions and anything that you wish the doctor to check for)

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Conditions For Boarding My Pet And I Fully Intend To Pick Up My Pet On The Above Date Specified. If Circumstances Change, I Will Notify The Practice Of The New Pick-Up Date.

The hospital shall not be responsible for the loss, theft or destruction of any personal property left with the above pet.

Medical Illness Policy

Canyon Small Animal Hospital

NEW CLIENT INFORMATION FORM

Date:

Owner's Name:

Street 1:

Street 2:

Owner's Address:

City:

State:

Zip:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Employer:

Driver's License Number:

Email Address:

How did you become aware of us?

Pet's Name:

Pet's Breed:

Pet's Color:

Pet's Sex:

Male

Female

option1

option2

Pet's Date Of Birth: option1
option2

Date Of Most Recent Vaccinations:

May we contact your previous veterinarian for a records transfer? Yes
No
Not Applicable
option1
option2

Previous Clinic's Name:

Street 1:

Previous Clinic's Address:

Street 2:
City:
State:
Zip:

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

DROP-OFF RELEASE FORM

Today's Date:

Owner's Name:

Owner's Phone Number:

Street 1:

Street 2:

Owner's Address:

City:
State:
Zip:

Pet's Name:

Reason For Visit:

Will Your Pet Be Fed Prior To Arrival? Yes
No

Is Your Pet On Heartworm Prevention? Yes
No

If You Answered
"Yes" To The
Previous Question
And You Would Like
To Refill Your
Pet's Heartworm
Medication, Then
Please Specify The
Name Of The Desired
Medication:

Is Your Pet On Flea Yes
Prevention? No

If You Answered
"Yes" To The
Previous Question
And You Would Like
To Refill Your
Pet's Flea
Prevention
Medication, Then
Please Specify The
Name Of The Desired
Medication:

Has Your Pet Been Yes
Checked For No
Intestinal No
Parasites In The
Last 6 Months?

Has Your Pet Ever Yes
Had Any Reaction To No
Medications?

Has Your Pet Ever Yes
Had Any Reaction To No
Vaccines?

Has Your Pet Ever Yes
Had Any Reaction To No
Anesthesia?

Is Your Pet Yes
Currently On Any No
Medication(s)?

If "Yes", Please
List The Name Of
The Medication And
The Dosage:

HAS YOUR PET SHOWN ANY SIGN OF THE FOLLOWING?:

Vomiting? Yes
 No

Diarrhea?	Yes
	No
Listless?	Yes
	No
No Appetite?	Yes
	No
Weakness?	Yes
	No
Coughing?	Yes
	No
Gagging?	Yes
	No
Scratching?	Yes
	No
Shaking Head?	Yes
	No
Scooting?	No
	Yes
Seizures?	Yes
	No
Abnormal Amount Of Urination?	Yes
	No
Abnorma Amount Of Drinking?	Yes
	No
Limping?	Yes
	No
Abnormal Weight Loss Or Gain?	Yes
	No
Unusual Lumps Or Bumps?	Yes
	No

TESTS & SERVICES TO BE PERFORMED DURING THIS VISIT:

Puppy/Kitten
Wellness Exam
Annual Wellness
Exam
Intestinal Parasite
Exam
Deworm (If Needed)
Heartworm Test

FELV/FIV Test

Bath

Grooming

Other (Please Specify):

Do authorize to take radiographs if necessary?	Yes
	No

May We Sedate/Anesthetize Your Pet If Necessary?	Yes
	No

By Clicking The "Submit" Button, I Agree With All Of The Following: The practice is to use all reasonable precaution against injury, escape, or death of my pet. The practice and staff WILL NOT be held liable for any problems that develop provided reasonable care and precautions are followed. I understand that ANY problem that develops with my pet while I'm absent will be treated as deemed best by the staff veterinarians and I ASSUME FULL RESPONSIBILITY for the treatment expense involved. I agree to pay fees for all services rendered at the time my pet is discharged from the practice or the service is otherwise terminated. I agree to pay for the reasonable costs of collection, attorneys fees and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the practice is located. If I neglect to pick up my pet within 7 days of the date below and do not notify the practice within that time frame, the practice may assume that the pet is abandoned and is hereby authorized to dispose of the pet as deemed best and/or necessary.

Client Name:

Client Name:

Client Phone Number:

Alternative Phone Number:

Client E-mail Address:

Pet's Name:

Name Of Medication To Be Refilled:

Quantity To Be Refilled:

Current Dosage Given:

Any Side Effects Seen?	Yes
	No

Date Of Pet's Most Recent Exam:

Additional
Comments:

We Will Contact You After Your Request Has Been Reviewed By A Doctor.
Please Allow 24 To 48 Hours For Processing Of Your Request.

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent
And 1=Poor

Professionalism Of
Our Staff:

Cleanliness Of Our
Facility:

Quality Of Services
Received:

Overall Impression
Of Our Practice:

Did You Have To Wait Past Your Scheduled Appointment Time? Yes
No

If You Answered "Yes" To The Previous Question, Then Please Tell Us How Long You Had To Wait For Your Appointment:

Please Feel Free To Leave Us Any Additonal Comments:

Client Name:

Pet's Name:

Client Phone Number:

Client E-mail Address:

Name Of Medication To Be Refilled:

Quantity To Be Refilled:

Current Dosage Given:

Any Side Effects Seen? Yes
No

Date Of Pet's Most Recent Exam:

Driver's License

Number:

How did you become
aware of us?

Pet's Name:

Pet's Breed:

Pet's Color:

Pet's Sex: Male
Male
Neuter
Female
Female
Spay

Pet's Date Of
Birth:

Date Of Most Recent
Vaccinations:

May we contact your
previous Yes
veterinarian for a No
records transfer?

Previous Clinic's
Name:

Street 1:
Street 2:
Previous Clinic's
Address: City:
State:
Zip:

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms &
Policies Of This Practice.

NEW CLIENT INFORMATION FORM

NEW CLIENT INFORMATION FORM

Date:

Owner's Name:

Spouse' Name:

Street 1:
Street 2:
Mailing Address: City:
State:
Zip:

Physical Address: Street 1:
Street 2:
City:
State:
Zip:

Best Contact
Number:
Home Phone Number:
Cell Phone Number:
Work Phone Number

May we call you at
work?

E-Mail Address:

Driver's License
Number:

How did you become
aware of us?

Pet #1

Pet's Name:

Pet's Species: Canine
Feline
Other

Pet's Breed:

Pet's Color:

Pet's Sex:

Pet's Date Of
Birth:

Date Of Most Recent
Vaccinations:

Does your pet(s)
have any chronic
health problems?

(Kidney disease,
heart disease,
arthritis,
diabetes,
allergies, drug
reactions, skin
conditions, etc.)

Yes
No

Please describe:

Is your pet(s)
currently taking
medication or on a

Yes
No

special diet?

Please describe:

Pet # 2

Pet's Name:

Canine

Pet's Species:

Feline

Other

Pet's Breed:

Pet's Color:

Pet's Sex:

Pet's Date Of
Birth:

Date Of Most Recent
Vaccinations:

Does your pet(s)
have any chronic
health problems?
(Kidney disease,
heart disease,
arthritis,
diabetes,
allergies, drug
reactions, skin
conditions, etc.)

Yes

No

Please describe:

Is your pet(s)
currently taking
medication or on a
special diet?

Yes

No

Please describe:

Previous Clinic's
Name:

May we contact your
previous
veterinarian for a
records transfer?

Yes

No

Not Applicable

Street 1:

Street 2:

Previous Clinic's
Address:

City:

State:

Zip:

By clicking the "Submit" button, I certify that I assume responsibility for all charges incurred in the treatment and care of my animal(s). I also understand that

these charges will be paid at the time services are rendered and that a deposit may be required for surgery and hospitalization.

CLIENT SATISFACTION SURVEY

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor

Professionalism Of
Our Staff:

Cleanliness Of Our
Facility:

Quality Of Services
Received:

Overall Impression
Of Our Practice:

Did You Have To
Wait Past Your Yes
Scheduled No
Appointment Time?

If You Answered
"Yes" To The
Previous Question,
Then Please Tell Us
How Long You Had To
Wait For Your
Appointment:

Please Feel Free To
Leave Us Any
Additonal Comments:

NEW CLIENT INFORMATION FORM

NEW CLIENT INFORMATION FORM

Date:

Owner's Name:

Street 1:

Street 2:

Owner's Address:

City:

State:

Zip:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Email Address:

Employer:

Driver's License

Number:

How did you become
aware of us?

Pet's Name:

Pet's Breed:

Pet's Color:

Male

Female

Pet's Sex:

option1

option2

option1

option2

Pet's Date Of
Birth:

Date Of Most Recent
Vaccinations:

Previous Clinic's
Name:

Previous Clinic's
Phone Number

Yes

No

Not Applicable

May we contact your
previous
veterinarian for a
records transfer?

option1

option2

option1

option2

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Policies Of This Practice.

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent
And 1=Poor

Professionalism Of
Our Staff:

Cleanliness Of Our
Facility:

Quality Of Services
Received:

May we contact your previous veterinarian for a records transfer? Yes
No
Not Applicable

Previous Clinic's Name:

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor

Professionalism Of Our Staff:

Cleanliness Of Our Facility:

Quality Of Services Received:

Overall Impression Of Our Practice:

Did You Have To Wait Past Your Scheduled Appointment Time? Yes
No

If You Answered "Yes" To The Previous Question, Then Please Tell Us How Long You Had To Wait For Your Appointment:

Please Feel Free To Leave Us Any Additonal Comments:

Client and Patient Information

Today's Date:

Owner's Name:

Spouse's Name

Owner's Address Street 1:

Street 2:

City:
State:
Zip:

Home Phone Number:

Cell Phone Number:

Spouse's Cell Phone
Number:

Work Phone Number:

Spouse's Work Phone
Number:

Emergency Contact:

Emergency Contact's
Phone Number:

E-mail Address

Wouldn't you like Yes
reminders e-mailed? No

Patient Name:

Patient Species:

Patient's Date of
Birth:

Patient's Sex:

Patient's Breed:

Patient's Coat
Color:

Does your pet have Yes
any medical No
conditions? Unknown

If so, please
explain:

Is your pet on any Yes
medications? No

If so, which
one(s)?

How did you hear
about us?

If referred by a
friend, who may we
thank?

We thank you for allowing us to take care of your pet. In order to provide the best possible care for your loved one, we require that all fees are due at the time services are rendered. We accept several payment options, including: cash, personal checks, debit cards, Visa, Discover, and American Express. Care Credit payment plans are gladly accepted. A receptionist will be happy to discuss this monthly payment plan with you. Approval from Care Credit is required. We routinely provide written

estimates. Critical patients that need extended hospitalization will have their balance updated daily. We are glad to work with you and give multiple estimates in order to help us provide the medical care that your pet may need. In the end, we always want what is best for you and your best friend. By clicking "Submit", you agree to the above terms and conditions.

NEW CLIENT INFORMATION FORM

Date:

Owner's Name:

Street 1:

Street 2:

Owner's Address:

City:

State:

Zip:

Email Address

Home Phone Number:

Work Phone Number:

Cell Phone Number:

How did you become aware of us?

Employer:

Driver's License Number:

Pet's Name:

Pet's Breed:

Pet's Color:

Male

Female

Pet's Sex:

Male Neutered

Female Spayed

Pet's Date Of Birth:

Date Of Most Recent

Vaccinations:

Previous Clinic's Name:

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Client Name:

Client Phone Number:

Alternative Phone Number:

Client E-mail

Address:

Pet's Name:

Name Of Medication

To Be Refilled:

Quantity To Be

Refilled:

Current Dosage

Given:

Any Side Effects Yes

Seen? No

Date Of Pet's Most

Recent Exam:

Additional

Comments:

Please Allow 24 To 48 Hours For Processing Of Your Request.

We Will Contact You After Your Request Has Been Reviewed By A Doctor.

Full Name

Pet's Name

First Date Request

Second Date Request

1st Contact Phone

Number

2nd Contact Phone

Number

E-Mail Address

Reason for visit:

Appointment requests will be checked every 24-48 business hours. If you have an emergency or need immediate assistance please call the clinic direct at 407-892-3415.

Thank You.

NEW CLIENT INFORMATION FORM

Date:

Owner's Name:

Street 1:

Street 2:

Owner's Address:

City:

State:

Zip:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Driver's License
Number:
How did you become
aware of us?
Referral Client's
Name:
Pet's Name:
Pet's Breed:
Pet's Color:

Pet's Sex: Male
Female
Spayed Female
Neutered Male

Pet's Date Of
Birth:
Date Of Most Recent
Vaccinations:
Previous Clinic's
Name:

Street 1:
Street 2:
Previous Clinic's
Address: City:
State:
Zip:

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.

BOARDING REGISTRATION FORM

Drop-Off Date
Requested:
Pick-Up Date
Requested:
Owner's Name:
Owner's Phone
Number

Street 1:
Street 2:
Owner's Address: City:
State:
Zip:

Pet's Name:

Owner's Phone
Number:

Street 1:

Street 2:

Owner's Address:

City:

State:

Zip:

Pet's Name:

Reason For Visit:

Is Your Pet On
Heartworm
Prevention?

Yes

No

Yes

No

Is Your Pet On Flea
Prevention?

Yes

No

Not Applicable

option1

option2

If You Answered
"Yes" To The
Previous Question
And You Would Like
To Refill Your
Pet's Flea
Prevention
Medication, Then
Please Specify The
Name Of The Desired
Medication:

If You Answered
"Yes" To The
Previous Question
And You Would Like
To Refill Your
Pet's Heartworm
Medication, Then
Please Specify The
Name Of The Desired
Medication:

Has Your Pet Been
Checked For
Intestinal
Parasites In The

Yes

No

option1

Scotting?	Yes
	No
Seizures?	Yes
	No
Abnormal Amount Of Urination?	Yes
	No
Abnorma Amount Of Drinking?	Yes
	No
Limping?	Yes
	No
Abnormal Weight Loss Or Gain?	Yes
	No
Unusual Lumps Or Bumps?	Yes
	No

TESTS & SERVICES TO BE PERFORMED DURING THIS VISIT:

Puppy/Kitten
 Wellness Exam
 Annual Wellness Exam
 Intestinal Parasite Exam
 Deworm (If Needed)
 Heartworm Test
 FELV Test
 FIV Test
 Bath
 If "Yes", Please List The Name Of The Medication And The Dosage:
 Other (Please Specify):
 May We Sedate/Anesthesize Your Pet If Necessary?

Yes
No

By Clicking The "Submit" Button, I Agree With All Of The Following: The practice is to use all reasonable precaution against injury, escape, or death of my pet. The practice and staff WILL NOT be held liable for any problems that develop provided reasonable care and precautions are followed. I understand that ANY problem that develops with my pet while I'm absent will be treated as deemed best by the staff veterinarians and I ASSUME FULL RESPONSIBILITY for the treatment expense involved. I agree to pay fees for all services rendered at the time my pet is discharged from the practice or the

service is otherwise terminated. I agree to pay for the reasonable costs of collection, attorneys fees and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the practice is located. If I neglect to pick up my pet within 7 days of the date below and do not notify the practice within that time frame, the practice may assume that the pet is abandoned and is hereby authorized to dispose of the pet as deemed best and/or necessary.

Client Name:

Client Phone

Number:

Alternative Phone

Number:

Client E-mail

Address:

Pet's Name:

Name Of Medication

To Be Refilled:

Quantity To Be

Refilled:

Current Dosage

Given:

Any Side Effects Yes

Seen? No

Additional

Comments:

We Will Contact You After Your Request Has Been Reviewed By A Doctor.

Please Allow 24 To 48 Hours For Processing Of Your Request.

CLIENT SATISFACTION SURVEY

Date Of Your Visit:

Please Indicate How You Would Rate Us Based On A Scale From 1 to 5, Where 5=Excellent And 1=Poor

Professionalism Of

Our Staff:

Cleanliness Of Our

Facility:

Quality Of Services

Received:

Overall Impression

Of Our Practice:

Did You Have To

Wait Past Your Yes

Scheduled No

Appointment Time?

If You Answered

"Yes" To The

Previous Question,

Then Please Tell Us
How Long You Had To
Wait For Your
Appointment:

Please Feel Free To
Leave Us Any
Additional Comments:

NEW CLIENT INFORMATION FORM

Date:

PATIENT INFORMATION

Pet's Name:

Is Your Pet a Dog Dog
or Cat? Cat

Pet's Date Of
Birth:

Pet's Sex: Male
 Female

Pet's Breed:

Pet's Color:

Is Your Pet Yes
Neutered or Spayed? No

At What Age was
Your Pet Neutered
or Spayed?

 Friend
 Breeder
 / Kennel
Where Did You Shelter
Obtain Your Pet? / Humane
 Society
 Rescue
 Pet shop
 Stray

At What Age Did You
Obtain Your Pet?

Does Your Pet Have Yes
a Microchip? No

What Brand of Pet
Food Does Your Pet
Eat?

Has Your Pet Yes
Received a Rabies No
Vaccine in the
Past?

If Your Pet is a Dog, Have They received a Distemper and Parvovirus (DHLP) Vaccine in the Past?	Yes No Not Applicable,My pet is a cat. Not Sure
If Your Pet is a Dog, Have They Received a Bordetella (Kennel Cough) Vaccine in the Past?	Yes No Not Applicable,My pet is a cat. Not Sure
If Your Pet is a Dog, Have They Received a Lyme Disease Vaccine in the Past?	Yes No Not Applicable,My pet is a cat. Not Sure
If Your Pet is a Cat, Have They Received an Upper Respiratory Vaccine (FVRCP) in the Past?	Yes No Not Applicable,My pet is a dog Not Sure
If Your Pet is a Cat, Have They Recieved a Feline Leukemia Vaccine in the Past?	Yes No Not Applicable,My pet is a dog Not Sure
Date Of Most Recent Vaccinations:	
If Your Pet is a Dog, Have They Previously Had a Heartworm Test?	Yes No Not Applicable,My pet is a cat. Not Sure
Date of Most Recent Heartworm Test:	
If Your Pet is a Cat,Have They Previously Been Tested for Feline Leukemia?	Yes No Not Applicable,My pet is a dog Not Sure
If Your Pet is a Cat, Have They Previously Been Tested for Feline Immunodeficiency Virus (FIV)?	Yes No Not Applicable,My pet is a dog Not Sure

Work Phone Number:

Cell Phone Number:

Driver's License
Number:

Social Security
Number: (Required
if checks will be
written at the
hospital)

Employer:

Occupation:

Business Phone
Number

Street 1:

Street 2:

Business Address

City:

State:

Zip:

Name of Spouse or
Co-Owner:

Spouse/Co-Owner
Phone Number:

How did you become
aware of us?

We will gladly prepare a written estimate of service fees if you desire. Please ask the receptionist or technician that assists you in the hospital.

All professional fees are due at the time of services rendered.

In the case of extensive medical or surgical procedures a deposit will be required upon admission and the remainder of the balance will be due at discharge.

By Clicking The "Submit" Button, I Certify That I Am In Agreement With All Terms & Policies Of This Practice.