



## Harborfront Hospital for Animals and Veterinary Dental Solutions

James Moore, DVM

(veterinary dental specialist)

### **Welcome!**

Thank you for choosing us as your referral specialist!

So that we may provide the most comprehensive care for your pet, please complete this form.

### Client Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email: \_\_\_\_\_

Driver's Lic: \_\_\_\_\_ DOB: \_\_\_\_\_

Alternative Contact/ Spouse: \_\_\_\_\_

Alt/ Spouse #: \_\_\_\_\_

### Pet Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

*Circle all that apply*

Canine

Feline

Other

Male

Female

Spayed Female

Neutered Male

**OVER ->**

Breed: \_\_\_\_\_

Current Medications/Supplements and Dosage:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Last Dosage of Meds: \_\_\_\_\_

Medication Reaction (list type of med given and reactions:)

\_\_\_\_\_  
\_\_\_\_\_

Any known anesthetic problems?    **YES**            **NO**    If yes please describe:

\_\_\_\_\_

Any previous medical problems? \_\_\_\_\_

\_\_\_\_\_

Reason for visit/presenting problem? \_\_\_\_\_

\_\_\_\_\_

Referral Information:

Name of Clinic: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Primary Care Veterinarian (if not referring veterinarian): \_\_\_\_\_

\_\_\_\_\_