



New Patient Questionnaire

Owner's Information:

First Name: _____ Surname: _____

Co-Owner: _____

Address: _____ APT # _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work: _____ Cell: _____

E-mail: _____

Pet's Information

Pet's Name: _____ Dog: _____ Cat: _____ Sex: _____ Neutered/Spayed?: _____

Breed: _____ Colour: _____

Date of Birth: _____/_____/_____ Up to Date on Vaccines?: Yes ___ No ___

Referral Information:

Referring Veterinarian: _____

Referring Clinic: _____

Presenting Problem: _____

Is your pet currently taking any medication? Y: ___ N: ___ If Yes, what are they taking?

Medication: _____ Last Given: _____

Medication: _____ Last Given : _____

Medication: _____ Last Given: _____

Pet Insurance: Y ___ N ___ If yes, which company? (circle one):

Trupanion Western PetCare OSPCA

Other (Specify: _____)