

Stafford Oaks Veterinary Hospital  
927 Dulles Avenue  
Stafford, TX 77477  
(281) 499-3538 Phone (281) 499-3854

Dr. Michael Moore  
Dr. Mike Brady  
Dr. Jennifer Parker  
Dr. Brian Smith

## Welcome to our Hospital!

Date: \_\_\_\_\_

Office Use Only

Account #: \_\_\_\_\_ WC \_\_\_\_\_

Attending DR: \_\_\_\_\_ TYC \_\_\_\_\_

### Owner Information

Client Information:

Name \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Spouse's Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Place Of Employment \_\_\_\_\_ Best Time To Reach You \_\_\_\_\_

Driver's License# \_\_\_\_\_ Email Address \_\_\_\_\_

### How did you hear about us?

- |  |   |
|--|---|
| <input type="checkbox"/> Yellow Pages  | <input type="checkbox"/> Texas Shih Tzu Rescue    |
| <input type="checkbox"/> Hospital Sign/Drive By                              | <input type="checkbox"/> Houston Humane Society   |
| <input type="checkbox"/> Welcome Card  | <input type="checkbox"/> SPCA                     |
| <input type="checkbox"/> HOPE  | <input type="checkbox"/> Veterinary Pet Insurance |
| <input type="checkbox"/> CAPS  | <input type="checkbox"/> FBISD/STAR               |
| <input type="checkbox"/> Referred by another client: Client Full Name: _____ |   |

### Patient Information

Pet's Name: \_\_\_\_\_ Color: \_\_\_\_\_ Breed: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_

Any prior illness or surgery? \_\_\_\_\_

Currently on any special diet/medications? \_\_\_\_\_

Any known drug allergies or reactions? \_\_\_\_\_

Microchip Identification # \_\_\_\_\_

Pet's Name: \_\_\_\_\_ Color: \_\_\_\_\_ Breed: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_

Any prior illness or surgery? \_\_\_\_\_

Currently on any special diet/medications? \_\_\_\_\_

Any known drug allergies or reactions? \_\_\_\_\_

Microchip Identification # \_\_\_\_\_

Do you have past vaccination history from another veterinarian? Yes or No

Previous Veterinarian Name: \_\_\_\_\_ Hospital Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

**ALL FEES ARE DUE AT TIME SERVICES ARE RENDERED**

Please indicate choice of payment:

- Cash     Check     VISA     Mastercard     AMEX     Discover