

Prairie Ridge Veterinary Clinic

www.prvc.net

Dr. Rodney Yetter, DVM
201 S. Prairie Ridge Drive

Havana, IL 62644

309-543-2091

WELCOME BACK TO OUR OFFICE

Today's Date _____

Name _____ Spouse/other name _____

Children's names/ages _____

Street _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Other phone(specify) _____

Employer _____ Email address _____

Social security number _____ Emergency contact name/number _____

Best time/place to call you regarding your pet's care _____

What food does your pet eat? _____

Canned or dry? _____

Is your pet fed any table scraps(people food)? _____

How often do you bathe/brush your pet? _____

How much time does your pet spend outdoors? _____

Where does your pet sleep? _____

How much time does a family member spend with your pet per day? _____

How do you view your pet(s) in terms of overall health concerns/issues?

- As a family member (I am concerned about all health issues/recommendations) Check any of the following that are of concern to you regarding your pet's behavior/health:
- As a pet (I am not concerned about all preventative and wellness issues)

Is your pet spayed or neutered?	No	Yes	<input type="checkbox"/> Excessive barking	<input type="checkbox"/> Straying from home
If no, do you plan to have it done?	No	Yes	<input type="checkbox"/> House breaking	<input type="checkbox"/> Itching/scratching
Do you plan to breed your pet?	No	Yes	<input type="checkbox"/> Wetting/spraying in the house	<input type="checkbox"/> Overly rambunctious
Does your pet have any drug allergies?	No	Yes	<input type="checkbox"/> Problems around children	<input type="checkbox"/> Biting
Do you take your pet with you on vacation?	No	Yes	<input type="checkbox"/> Shedding	<input type="checkbox"/> Clawing or digging
Will you ever need to board your pet?	No	Yes	<input type="checkbox"/> Jumping	<input type="checkbox"/> Bad breath
Do you use your pet for hunting?	No	Yes	<input type="checkbox"/> Other _____	
Is your pet on a preventative program for controlling external parasites (fleas and ticks)?	No	Yes	Which of the following services might you utilize:	
Is your pet on a preventative program for controlling internal parasites(heartworm,roundworm,hookworm, etc)?	No	Yes	<input type="checkbox"/> Lodging/boarding facility	<input type="checkbox"/> Evening hours
Does your pet spend long periods of time alone during the day?	No	Yes	<input type="checkbox"/> Referral rewards program	<input type="checkbox"/> Grooming
Are you interested in having your pet micro chipped?	No	Yes	<input type="checkbox"/> Behavior training classes	<input type="checkbox"/> Day care
Has your pet ever had dental care?	No	Yes	<input type="checkbox"/> Value package programs	<input type="checkbox"/> Product trials
Do you understand the health benefits and life extending effects of providing proper dental care for pets?	No	Yes	Do you have more than one pet? If so, please list all pets below, starting with today's patient:	
Do you have veterinary pet insurance?	No	Yes	Name:	M/F Breed Age Last Exam
			_____	_____
			_____	_____
			_____	_____
			_____	_____