Animal Emergency and Referral Center of Minnesota
New Client Information and Pet History Form for Dentistry Services

Owner Name _____

Address _____

City_____State_____ Zip_____

Primary Phone (_____)_____ Other Phone (_____)_____

Email *(this will be used for in-house communications only)* _____

Pet's Vet Clinic _____ Doctor_____

Pet Name _____ (circle) *canine feline equine other*

Breed_____ Birth date or Age_____ Sex: (circle) *M neuter F spay*

Reason for Visit _____

What tooth or teeth are affected? _____

When did you first notice the problem? Has it gotten worse?_____

Circle any current symptoms: *sneezing, nasal discharge, eye discharge, not eating well, weight loss, bleeding gums, hissing/growling at food, dropping food, behavioral change, bad breath, facial swelling, other* _____

How is your pet for examinations? _____

Past Care:

Please indicate past dental problems or conditions _____

When and how were they treated? (ex:Extraction 5-2010)_____

When was your pet's teeth last cleaned? _____

Where was the procedure done? Vet Clinic ___ Groomer ___ Other _____

Diet: What is your pet's current diet? Dry _____ Canned _____ People food _____

Other treats or chew toys?_____

Does he/she chew on non-food/non-toy items like rocks, cage, etc?_____

Has their food preference changed recently? If yes, please explain (ex: used to eat dry food but now only soft foods, etc) _____

Current Care:

Do you provide home dental care? No __

Yes__ Brush__ Dental Diet __ Chews__ Rinses__ Water Additive___

Are you interested in learning about other home care options: No ___ Yes ___

Did you bring records/x rays with you or did your Vet send them? _____

Please list below current and past drugs **Dosage** **Did this treatment help at all?**

_____

_____

**List any known drug sensitivity _____