Welcome

We know your pet's health is important and we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form completely. Thank you!

REGISTRATION

Date _____

Owner _____ SS# _____

Address _____

_____

Spouse _____ SS# _____

Home Phone _____ Work Phone _____ Spouse Work Phone _____

Emergency Contact Name _____ Phone _____

How did you learn about our clinic? ☐ Yellow Pages ☐ Recommendation
☐ Sign ☐ Other _____

If recommended, by whom? _____

Number of pets: Dogs _____ Cats _____ Other (specify) _____

Reason for visit _____

PET HEALTH HISTORY

Name of pet _____ ☐ Dog ☐ Cat ☐ Other _____

Breed _____ Color _____ Birthdate _____

☐ Male ☐ Neutered ☐ Female ☐ Spayed

Vaccination History (Date and type of last vaccinations) _____

_____

Please check (✓) any symptons or problems that you have noticed about your pet.

- ☐ Behavorial Problems
- ☐ Bleeding Gums
- ☐ Breathing Problems
- ☐ Coughing
- ☐ Diarrhea
- ☐ Eye Bulging or Bloodshot
- ☐ Gagging
- ☐ Lack of Appetite
- ☐ Limping
- ☐ Loss of Balance
- ☐ Scooting
- ☐ Scratching
- ☐ Seems Depressed
- ☐ Shaking Head
- ☐ Sneezing
- ☐ Thirst and/or Urination Increased
- ☐ Vomiting
- ☐ Weakness
- ☐ Other _____

Pet's current medications _____

Describe your pet's diet _____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner _____ Date _____

Method of Payment ☐ Cash ☐ Check ☐ MasterCard ☐ Visa ☐ Other _____