

Welcome

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in 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 of our clinic? Yellow Pages Sign Recommendation 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 Netuered Female Spayed
Vaccination History (Date and type of last vaccinations) _____

Please check any symptoms or problems that you have noticed about your pet.

- | | | |
|---|---|--|
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Gagging | <input type="checkbox"/> Seems Depressed |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Shaking Head |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Limping | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Thirst and/or Urination Increased |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scooting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Scratching | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Other _____ | | |

Pet's current medications _____

Describe your pet's diet _____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in 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 _____