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

Owner: _____ Date: _____
Address: _____ Employer: _____
_____
Significant Other: _____ Employer: _____
Phone: _____ Work Phone: _____ Email: _____
Emergency Contact Name: _____ Phone _____
How did you learn about our clinic? ☐ Sign Outside ☐ Yellow Pages ☐ Facebook ☐ Recommendation
☐ Website ☐ News Paper ☐ 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: _____
☐ Undetermined ☐ Male ☐ Neutered ☐ Female ☐ Spayed
Vaccination History (date and type of last vaccinations): _____
_____
_____
_____

Please check (✓) any symptoms or problems that you have noticed about your pet:

- ☐ Behavioral 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: _____