



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

Owner(s) _____ Date _____

Address _____ DL # _____

City _____ State _____ Zip Code _____

Preferred Method of Contact: Home Phone Cell Phone Work Phone E-Mail

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail Address _____

Emergency Contact _____ Phone _____

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

Recommended, if so by whom? _____

PET HEALTH HISTORY

Name of pet _____ Dog Cat Other _____

Breed _____ Color _____ Birthdate _____

Male Neutered Female Spayed

Reason for Visit _____

Vaccination History (Date, Type, and Name of Facility) _____

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

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

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 treatment.

Signature of Owner _____ Date _____

Accepted forms of payment: Cash, Check, MasterCard, VISA, Care Credit