

# 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 ensure the best care possible, please take the time to fill in this form completely. Thank You!

## REGISTRATION

Date \_\_\_\_\_

Owner First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**EMAIL** \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Spouse \_\_\_\_\_ Spouse Work Phone \_\_\_\_\_ Spouse Cell Phone \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

How did you learn of our clinic?  Yellow Pages  Recommendation  Website  Internet  
 Sign  Other  Moneymailer  Yellowpages.com

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 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 surgical treatment

Signature of Owner \_\_\_\_\_

Method of payment  Cash  Check  Master Card  VISA  Other \_\_\_\_\_