



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 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 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 _____ Date _____

Method of payment Cash Check MasterCard VISA Other _____

