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_____ DATE OF BIRTH_____

Address_____

City/State/Zip_____ E-Mail_____

Cell_____ Home_____ Work_____

Spouse_____ DATE OF BIRTH_____

Spouse's Cell_____ Work_____

Emergency Contact Name_____ #_____

How did you learn of our clinic? ☐ Yellow pages ☐ Sign ☐ Other_____

If recommended, by whom?_____

PET HEALTH HISTORY

Name of pet_____ Breed_____ DOB _____ Color_____

Female Spayed Male Neutered Previous Vet_____#_____

Vaccination History (Date and type of last vaccinations) _____

Number of pets : Dogs _____ Cats _____ Other _____

Reason for visit_____

__ Behavior Problems	__ Lack of Appetite	__ Sneezing
__ Bleeding Gums	__ Limping	__ Thirst and/or Urination Increased
__ Breathing Problems	__ Loss of Balance	__ Vomiting
__ Coughing	__ Scooting	__ Weakness
__ Diarrhea	__ Scratching	__ Other _____
__ Eye Bulging or Bloodshot	__ Seems Depressed	
__ Gagging	__ 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 (circle one) Cash Check MasterCard Visa CareCredit AmEx