

Welcome

Thank you for giving us the opportunity to care for your pet. We will 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 _____ SSN _____
Address _____ Home phone _____ Cell phone _____
City _____ State _____ Zip _____
Place of Employment _____ Phone _____ E-mail address _____
Spouse _____ SSN _____ Cell Phone _____
Place of Employment _____ Phone _____ E-mail address _____
Emergency contact name _____ Phone _____
How did you learn of our clinic? _____ Yellow Pages _____ Sign _____ Recommendation _____ 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
How was pet acquired? _____ Breeder _____ Individual _____ Pet Store _____ Other _____
Date of Last Vaccine: _____

CANINE

Rabies _____
Dh1pp _____
Parvo _____
Bordetella _____
Heartworm Prev. YES NO (circle one)
Type _____

FELINE

100% Indoor YES NO (circle one)
Rabies _____
Fel-cvr _____
Leukocell _____
Leukemia Tested YES NO Date _____
FIV Tested YES NO Date _____

Medical History: _____
Previous Veterinarian _____

Please check any symptoms or problems that you have noticed about our pet:

___ Behavior Problems ___ Bleeding Gums ___ Breathing Problems ___ Coughing ___ Thirst
___ Diarrhea ___ Limping ___ Increased Urination ___ Scooting ___ Vomiting
___ Scratching ___ Seems Depressed ___ Loss of Balance ___ Sneezing ___ Weakness
___ Lack of Appetite ___ Shaking Head ___ Eye Problem ___ Gagging ___ Other _____

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. MUST BE 18 YEARS OR OLDER.

Signature of Owner _____ Date _____
Method of payment: Check _____ Cash _____ MC/Visa _____