

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 time to fill in this form completely. Thank You!

Registration

Owner's Name: _____ Today's Date: _____
Drivers License #: _____ Spouse Name: _____
Address: _____ Home Phone: _____
City & Zip Code: _____ Cell Phone: _____
Employer: _____ Work Phone: _____
E-mail Address: _____ Spouse Phone: _____
Emergency Contact: _____ Emergency Phone: _____
How did you learn of our hospital? Yellow Pages Newspaper Recommendation
 Sign Internet Other _____
If recommended, who may we thank? _____
Number of Pets: Dogs _____ Cats _____ Other _____
Reason for visit: _____
Would you prefer reminders by: Regular mail? Text Message? E-mail?

Pet Health History

Pet	Pet Name	Dog, Cat, Other	Breed/Color	Male, Female	Spayed? Neutered?	Date of Birth
1						
2						
3						

Vaccination, Medication and Diet History (Date and Type of last vaccinations, all medications and diet specifics): Please provide this information on the back of this sheet.

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 Increase | <input type="checkbox"/> Urination Changes | <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"/> Eye Problems |
| <input type="checkbox"/> Seems Depressed | <input type="checkbox"/> Gagging | <input type="checkbox"/> Shaking Head | <input type="checkbox"/> Other |

Authorization

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet(s). I assume responsibility for all charges incurred in the care of this animal(s). I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. I also authorize the hospital to use photos and/or other likeness of myself and/or my pet(s) for their medical record or other purposes. **MUST BE 18 OR OLDER TO AUTHORIZE.**

Signature of Owner: _____ Date: _____
Method of Payment: Cash Check MasterCard Visa Other _____