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.

- ☐ Behavior Problems
- ☐ Limping
- ☐ Loss of Balance
- ☐ Weakness
- ☐ Seems Depressed
- ☐ Lack of Appetite
- ☐ Thirst Increase
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Gagging
- ☐ Sneezing
- ☐ Urination Changes
- ☐ Coughing
- ☐ Scratching
- ☐ Shaking Head
- ☐ Bleeding Gums
- ☐ Breathing Problems
- ☐ Scooting
- ☐ Eye Problems
- ☐ 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 ______________________________