



# 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.

## Registration

Today's Date \_\_\_\_\_

Owner's Name \_\_\_\_\_ Spouse/Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Employer's Name & Address \_\_\_\_\_

What Phone Number Is Best to Reach You Regarding Your Pet? \_\_\_\_\_

In Case of EMERGENCY, Please Call \_\_\_\_\_

Please Describe Other Animals in the Household \_\_\_\_\_

Reason for Visit \_\_\_\_\_

## Pet Health History

Pet's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Type of Animal  Dog  Cat  Other \_\_\_\_\_ Sex  Male  Neutered  Female  Spayed

Breed \_\_\_\_\_ Color \_\_\_\_\_ Weight \_\_\_\_\_

Vaccination History (Date and Type of Last Vaccinations)

Please check any symptoms or problems that you have noticed about your pet.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bad Breath               | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Thirst and/or Urination Increased |
| <input type="checkbox"/> Behavior Problems        | <input type="checkbox"/> Limping          | <input type="checkbox"/> Vomiting                          |
| <input type="checkbox"/> Bleeding Gums            | <input type="checkbox"/> Loss of Balance  | <input type="checkbox"/> Weakness                          |
| <input type="checkbox"/> Breathing Problems       | <input type="checkbox"/> Scooting         | <input type="checkbox"/> Weight Problems                   |
| <input type="checkbox"/> Coughing                 | <input type="checkbox"/> Scratching       | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Seems Depressed  | _____  |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Shaking Head     | _____  |
| <input type="checkbox"/> Gagging                  | <input type="checkbox"/> Sneezing         |  |

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 understand that these charges must be paid for at the time of the release and that a deposit may be required for surgical treatment.

Signature of Owner/Agent \_\_\_\_\_ Date \_\_\_\_\_