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_____SS#_____Cell#_____

Address_____Place of Employment_____

City_____State_____Zip_____

Spouse_____SS#_____Cell#_____

Home Phone_____Work Phone_____Spouse Work Phone_____

Emergency Contact Name_____Phone_____

How did you learn of our clinic? _____ Yellow Pages _____Recommendation

_____Sign _____Other_____

If recommended, by whom?_____

Reason for visit_____

PET HEALTH HISTORY

Name of pet_____ _____Dog _____Cat _____Other_____

Breed_____ Color_____ Birthday or Age_____

Vaccination History (Date and type of last vaccinations)_____

_____

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

__Behavior Problems	__Eye Bulging or Bloodshot	__Loss of Balance	__Sneezing
__Bleeding Gums	__Gagging	__Scooting	__Thirst
__Breathing Problems	__Increased Urination	__Scratching	__Vomiting
__Coughing	__Lack of Appetite	__Seems Depressed	__Weakness
__Diarrhea	__Limping	__Shaking Head	__Other_____

Pet's current medications_____

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 or release and that a deposit may be required for surgical treatment.

Signature of Owner_____Date_____

Method of Payment: ___Cash ___MasterCard ___Visa ___Other **NO CHECKS ACCEPTED**