WELCOME

We know your pet's health is important and we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form completely. Thank You!

OWNER REGISTRATION

Full Name: _____ Phone: _____

Spouse's Name: _____ Spouse's Phone: _____

Street Address: _____ Home Phone: _____

Apt No: _____

City, State: _____ Zip Code: _____ SS Number: _____

Email: _____ DOB: _____

Employer: _____ Work Phone: _____

How did you learn about our clinic? ☐ Internet ☐ Facebook ☐ Recommendation ☐ Other

If recommended, by whom? _____

PET HEALTH HISTORY

(FORMS FOR ADDITIONAL PETS ON NEXT PAGE)

Name of Pet: _____ ☐ Dog ☐ Cat ☐ Other: _____

Breed: _____ Color: _____ DOB or Age: _____

(check all that apply) ☐ Male ☐ Female ☐ Undetermined Fixed? ☐ Yes ☐ No

Previous Vet: _____

City & State: _____ Phone Number: _____

Reason for Visit: _____

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

- ☐ Behavioral Problems
- ☐ Bleeding Gums
- ☐ Breathing Problems
- ☐ Coughing
- ☐ Diarrhea
- ☐ Eye Bulging or Bloodshot
- ☐ Excessive Thirst or Urination
- ☐ Gagging
- ☐ Lack of Appetite
- ☐ Limping
- ☐ Loss of Balance
- ☐ Scooting
- ☐ Scratching or chewing
- ☐ Seems Depressed
- ☐ Shaking Head
- ☐ Sneezing
- ☐ Vomiting
- ☐ Weakness
- ☐ Other: _____

Pet's Current Medications: _____

What does your pet normally eat? _____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for 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.

Signature of Owner: _____ Date: _____

Method of Payment: ☐ Cash ☐ Check ☐ CareCredit/ScratchPay ☐ Credit/Debit Card ☐ Other: _____

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