



# 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

OWNER'S NAME _____		TODAY'S DATE _____	
ADDRESS _____		CITY _____ STATE _____ ZIP _____	
HOME PHONE _____		WORK PHONE _____ CELL PHONE _____	
EMPLOYER'S NAME & ADDRESS _____			
SPOUSE'S/OTHER'S EMPLOYER & ADDRESS _____			
AT WHAT TIME _____		AND AT WHAT PHONE NUMBER _____ IS IT BEST TO CALL ABOUT YOUR PET? _____	
IN CASE OF <b>EMERGENCY</b> , PLEASE CALL _____			
PLEASE DESCRIBE OTHER ANIMALS IN HOUSEHOLD _____			
REASON FOR VISIT _____			

## PET HEALTH HISTORY

PET'S NAME _____		DATE OF BIRTH _____	
TYPE OF ANIMAL <input type="checkbox"/> DOG <input type="checkbox"/> CAT <input type="checkbox"/> OTHER _____			
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> NEUTERED <input type="checkbox"/> FEMALE <input type="checkbox"/> 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"/> 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 and/or Urination Increased	
<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"/> Weight Problems	
<input type="checkbox"/> Eye Bulging or Bloodshot	<input type="checkbox"/> Seems Depressed	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Gagging	<input type="checkbox"/> Shaking Head		
CURRENT MEDICATIONS, IF ANY _____			
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 also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner _____	Date _____
Method of payment <input type="checkbox"/> Cash <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Other _____	