



# 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 \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_

City/State/zip \_\_\_\_\_

Spouse \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

How did you learn of our clinic?  Recommendation  Sign  Website  
 Google  Facebook  Yellow Pages  Other

If recommended, by whom? \_\_\_\_\_

Number of pets: Dogs \_\_\_\_\_ Cats \_\_\_\_\_ Other \_\_\_\_\_

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

## Pet Health History

Name of pet \_\_\_\_\_  Dog  Cat  
 Other \_\_\_\_\_

Breed \_\_\_\_\_ Color \_\_\_\_\_ Birthday \_\_\_\_\_

Male  Neutered  Female  Spayed

Vaccination History (date and Type of last vaccinations) \_\_\_\_\_

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Behavior problems        | <input type="checkbox"/> Gagging          | <input type="checkbox"/> Seems depressed                   |
| <input type="checkbox"/> Bleeding gums            | <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Shaking head                      |
| <input type="checkbox"/> Breathing problems       | <input type="checkbox"/> Limping          | <input type="checkbox"/> Sneezing                          |
| <input type="checkbox"/> Coughing                 | <input type="checkbox"/> Loss of balance  | <input type="checkbox"/> Thirst and/or urination increased |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Scooting         | <input type="checkbox"/> Vomiting                          |
| <input type="checkbox"/> Eye bulging or bloodshot | <input type="checkbox"/> Scratching       | <input type="checkbox"/> Weakness                          |

Pet's current  
medications \_\_\_\_\_

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 or

Owner \_\_\_\_\_ Date \_\_\_\_\_