



Registration

Today's date: _____

Owner's name: _____ Spouse/Other _____

Address: _____ City: _____ State: _____ ZIP: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____ Driver's license number/state: _____

Employer's name: _____ Address: _____

At what number: _____ and what time: _____ is it best to call about your pet?

In case of **emergency**, please call: _____

Please describe other animals in your household: _____

Reason for today's visit: _____

Is there anyone we can thank for you coming here? _____

Pet Health History

Pet's name: _____ Type of animal: Dog Cat Other _____ Birthdate or age: _____

Sex: Male Female Neutered /Spayed Breed: _____

Color: _____ Weight: _____ Is your heartworm test current? Yes No

Does your pet have a microchip ID implanted? Yes No If no microchip, would you like us to implant one today? Yes No

Vaccination history (date and type of last vaccination): _____

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 problem |
| <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 at the time of release and that a deposit may be required for surgical treatment.

Signature of owner/agent: _____ Date: _____

Method of payment: Cash Check MasterCard VISA Other: _____