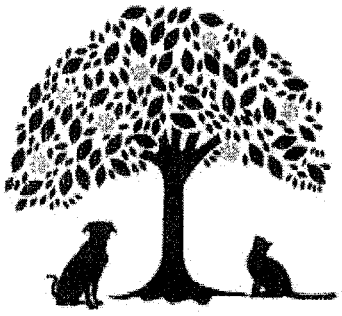

Welcome

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!

REGISTRATION

Owner: _____ Cellular Phone: _____

Significant Other: _____ Cellular Phone: _____

Address: _____

City,State, Zipcode: _____

E-mail: _____

Home Phone: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____

How did you learn about our clinic? ☐ Sign Outside ☐ Website ☐ Facebook ☐ Recommendation

If recommended, by whom? _____

Reason for Visit: _____

PET HEALTH HISTORY

Name of Pet: _____ ☐ Dog ☐ Cat

Birthday/Age: _____ Breed: _____ Color: _____

☐ Male ☐ Neutered ☐ Female ☐ Spayed

Vaccination History (date and type of last vaccinations): _____

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

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

Pet's current medications: _____

Describe your pet's diet: _____

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: _____