WELCOME! *Thank you for giving us the opportunity to care for your pet. We will be happy to answer any questions you have about your pet's health. To insure the best care possible, please take time to fill in this form completely. Thank you!*

TODAY'S DATE:______________________

REGISTRATION

OWNER'S NAME:______________________ SPOUSE/OTHER:______________________

ADDRESS:______________________ CITY:______________________ STATE:______ ZIP:__________

HOME PHONE:______________________ WORK PHONE:______________________ CELL PHONE:______________________

E-MAIL:______________________

SSN/SIN#:______________________ DRIVER'S LICENSE:______________________

EMPLOYER'S NAME & ADDRESS______________________

AT WHAT TIME______________________ AND AT WHAT NUMBER______________________ IS IT BEST TO CALL ABOUT YOUR PET?

IN CASE OF EMERGENCY, PLEASE CALL:______________________

PLEASE DESCRIBE OTHER AMINAL IN HOUSEHOLD:______________________

REASON FOR VISIT______________________

PET HEALTH HISTORY

PET'S NAME:______________________ DATE OF BIRTH:______________________

TYPE OF ANIMAL:______________________ BREED:______________________ COLOR:______________________

SEX:______________________ SPAYED/NEUTERED?______________________

VACCINATION HISTORY (Date and Type of Vaccinations, or attach copy from previous care)

____

____

____

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

________ Bad Breath	________ Lack of Appetite	________ Thirst and/or Urination Increased
________ Behavior Problems	________ Limping	________ Vomiting
________ Bleeding Gums	________ Loss of Balance	________ Weakness
________ Breathing Problems	________ Scooting	________ Weight Problem
________ Coughing	________ Scratching	________ Other: ________
________ Diarrhea	________ Seems Depressed	________
________ Eye Bulging or Bloodshot	________ Shaking Head	________
________ Gagging	________ Sneezing	________

CURRENT MEDICATIONS:______________________

DESCRIBE YOUR PET'S DIET:______________________ TREATS (KIND/HOW OFTEN)______________________

AUTHORIZATION

I hearby authorize the veterinarian to examine, prescribe for, or treat the above desribed 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. Finally, I aknowledge that any returned checks will result in a $25.00 fee

Signature of Owner/Agent:______________________ Date:______________________

Method of Payment: Cash Check Matercard/Visa/Discover CareCredit

ADVERTISING FEEDBACK

Please tell us how you heard about our practice: WEBSITE PHONEBOOK OTHER:______________________

REFERRED BY:______________________