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 pets health. To insure the best care possible, please take the time to fill in this form completely. *Thank you!* Colin R. Jeschke, DVM and The Staff of Abington Veterinary Center

REGISTRATION

Owner _____ Date _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Work Phone _____ Occupation _____

Email Address _____

Spouse/Co-Owner _____ Work Phone _____

Occupation _____

How did you learn about our practice? ☐ Phone book ☐ Recommendation ☐ Newspaper ☐ Previous Client ☐ Sign

Number of pets: Dogs _____ Cats _____ Other (Specify) _____

PET HEALTH HISTORY

Name of pet _____ ☐ Dog ☐ Cat ☐ Other _____

Breed _____ Color _____ Birth Date _____

Sex _____ Neutered/spayed ☐ Yes ☐ No If yes, at what age _____

Where did you obtain this pet? ☐ Friend ☐ Breeder ☐ Pet Shop ☐ Humane Society ☐ Other _____

At what age was the pet obtained? _____

For what purpose was the pet obtained? (check all that apply)

☐ Companionship ☐ Protection ☐ Breeding ☐ Show ☐ Other _____

Is your pet an indoor housepet? ☐ Yes ☐ No

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

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

Please list any prior illness/surgery(s) _____

Last date of dental cleaning _____

If cat, date of last Feline Leukemia Test _____ ☐ Positive ☐ Negative

Previous veterinarian(s) where past records can be obtained if necessary _____

AUTHORIZATION

I here by authorize Dr. Colin R. Jeschke, DVM and Abington Veterinary Center to examine, prescribe for and/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 the surgical treatment.

Method of payment: ☐ Cash ☐ Check ☐ Mastercard ☐ Visa

Signature of Owner or Agent _____ Date _____