



# WELCOME TO ARBOR HILLS VETERINARY CENTRE

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 possible care, please take the time to fill in this form completely. Thank you!

## REGISTRATION

Date \_\_\_\_\_

Owner \_\_\_\_\_ SS# \_\_\_\_\_  

First
Middle Initial
Last

Drivers License \_\_\_\_\_ Date of Birth \_\_\_\_\_  

State
Number

Spouse/Other \_\_\_\_\_ SS# \_\_\_\_\_  

First
Middle Initial
Last

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_  I would you like to receive correspondences via e-mail.

How did you learn of our facility?  Yellow Pages  Recommendation  
 Sign  Other \_\_\_\_\_

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

Number of pets: Dogs \_\_\_\_\_ Cats \_\_\_\_\_ Other (specify) \_\_\_\_\_

Reason for visit:  Veterinary Services  Grooming  Boarding  Retail Purchases  
(Please check all that apply)

## PET HEALTH HISTORY

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

Breed \_\_\_\_\_ Color \_\_\_\_\_ Birthdate \_\_\_\_\_

Male  Female Is your pet neutered: Yes No

Pets previous veterinarian/hospital \_\_\_\_\_

Please contact the above facility and have our pets records transferred.

Vaccination history (Date and type of last vaccinations) \_\_\_\_\_

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Behavior Problems  | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Sneezing                          |
| <input type="checkbox"/> Bleeding Gums      | <input type="checkbox"/> Limping          | <input type="checkbox"/> Thirst and/or Urination Increased |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Loss of Balance  | <input type="checkbox"/> Vomiting                          |
| <input type="checkbox"/> Coughing           | <input type="checkbox"/> Scooting         | <input type="checkbox"/> Weakness                          |
| <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Scratching       | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> Eye Problems       | <input type="checkbox"/> Seems Depressed  |  |
| <input type="checkbox"/> Gagging            | <input type="checkbox"/> Shaking Head     |  |

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

Describe your pet's diet \_\_\_\_\_

## AUTHORIZATION

I hereby authorize the veterinarian (and assistants the doctor may designate) 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.

Signature of Owner/Agent \_\_\_\_\_ Date \_\_\_\_\_

Method of payment:  Cash  Check  Credit Card