

# Welcome!



## REGISTRATION

Owner: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Email: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Spouse Phone: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
How did you learn about our clinic? (circle one) Internet Recommendation- Who can we thank?! \_\_\_\_\_  
Pet Pages Drove by Yellow Book Other: \_\_\_\_\_  
Number Of Pets: Dogs: \_\_\_\_\_ Cats: \_\_\_\_\_ Other (Specify): \_\_\_\_\_  
Reason For Your Visit: \_\_\_\_\_

## PET HEALTH HISTORY

Name of Pet: \_\_\_\_\_ Dog  Cat  Other(Specify)  \_\_\_\_\_  
Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Age or DOB: \_\_\_\_\_  
Male  Neutered  Female  Spayed  At what age was the pet obtained? \_\_\_\_\_  
From: Friend  Breeder  Pet Shop  Humane Society  Other (Specify)  \_\_\_\_\_  
Vaccination History (date and type of last vaccinations): \_\_\_\_\_  
Previous Vet: \_\_\_\_\_

Please check [  ] any symptoms that you have noticed about your pet...

- |   |  |  |
|---|--|--|
| <input type="radio"/> Behavior problems           | <input type="radio"/> Lack of appetite | <input type="radio"/> Sneezing                         |
| <input type="radio"/> Bleeding gums               | <input type="radio"/> Limping          | <input type="radio"/> Thirst and/or frequent urination |
| <input type="radio"/> Breathing problems          | <input type="radio"/> Loss of balance  | <input type="radio"/> Vomiting                         |
| <input type="radio"/> Coughing                    | <input type="radio"/> Scooting         | <input type="radio"/> Weakness                         |
| <input type="radio"/> Diarrhea                    | <input type="radio"/> Scratching       | <input type="radio"/> Other _____                      |
| <input type="radio"/> Eye(s) bulging or bloodshot | <input type="radio"/> Seems depressed  | _____  |
| <input type="radio"/> Gagging                     | <input type="radio"/> Shaking head     | _____  |

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.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Method of Payment: Cash Card(type) \_\_\_\_\_