



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!

Registration

Owner: _____ Date: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Alt Phone: _____
Email: _____
How did you learn of our clinic? Sign Facebook Google Mailing other: _____

Pet Health History

Name of pet: _____ Dog Cat other: _____
Breed: _____ Color: _____ Birthdate: _____
Sex: _____ Is your pet spayed/neutered? Yes No
Vaccine History (list date/type) _____

Please check off if your pet has any of the following symptoms: behavior problems
 bleeding gums breathing problems coughing diarrhea eye bulging/bloodshot
 gagging lack of appetite limping loss of balance scooting scratching
 seems depressed shaking head sneezing thirst and/or urination increased
 vomiting weakness other: _____

Pets current medications: _____

Pets current diet: _____

Authorization

I hereby authorize the veterinarian 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 for surgical treatment.

Signature of owner: _____ Date: _____

Method of payment: cash care credit mastercard visa other: _____

