Welcome

We know your pet's health is important and we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form completely. Thank You!

REGISTRATION

Owner: _____ Date: _____

Address: Street: _____

_____

City: _____

State: _____

Zip Code: _____ Employer:

Significant Other: _____ Employer: _____

Phone: _____ Work Phone: _____ Email: _____

Emergency Contact Name: _____ Phone _____

How did you learn about our clinic? ☐ Sign Outside ☐ Instagram ☐ Facebook ☐ Recommendation ☐ Website ☐ Coupon ☐ Other: _____

If recommended, by whom? _____

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

Reason for Visit: _____

PET HEALTH HISTORY

Name of Pet: _____ ☐ Dog ☐ Cat ☐ Other: _____

Breed: _____ Color: _____ Birthdate/ or Approx Age: _____

☐ Undetermined ☐ Male ☐ Neutered ☐ Female ☐ Spayed

Vaccination History (date and type of last vaccinations): _____

_____

_____

_____

If You Would Like for Us to Try and get Records Please indicate Previous Clinic Name and Phone:

_____

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

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

Pet's current medications: _____

Describe your pet's diet: _____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full

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responsibility for all charges incurred for 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:** _____