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 pet's health! To ensure the best care possible, please take the time to fill in this form completely.

Registration

Owner's Name ______________________ Spouse/other ______________________

Address ______________________ City ______________ State ________ Zip ________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Spouse/other Phone ______________ Email address ______________________

Registration

SS # /SIN ______________________ AND Driver's License # ______________

Employer's Name and Adderss ______________________

In case of emergency, please call ______________________

Reason for Today's Visit

☐ General Wellness Exam ☐ Illness ☐ Surgery/consult ☐ Boarding ☐ Grooming

Pet Health History (For spouse's pet information and additional pets, use the other side)

Pet's Name ______________________ Date of Birth ______________

Species: ___ Dog ___ Cat ___ Other (please specify) ______________________

Sex: ___ Male ___ Neutered ___ Female ___ Spayed

Breed: ______________ Color: ______________ Weight ______________

Vaccination history (date and type of last vaccination)

____

____

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

☐ Bad Breath ☐ Breathing Problems ☐ Gagging/Coughing ☐ Diarrhea ☐ Lack of Appetite

☐ Limping ☐ Scratching ☐ Seems Depressed ☐ Shaking Head ☐ Sneeezing

☐ Thirst and/or Urination Increased ☐ Vomiting ☐ Weakness

☐ Other ______________________

Current medications:

____

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Registration

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 understand that these charges must be paid at the time of release and a deposit may be required for surgical treatment.

Signature of owner/agent ______________________ Date ______________

Spouse's or additional pets

Pet's Name ______________________________ Date of Birth ______________

Species: ___ Dog ___ Cat ___ Other (please specify) ______________________________

Sex: ___ Male ___ Neutered ___ Female ___ Spayed

Breed: ____________________ Color: ____________________ Weight ____________

Vaccination history (date and type of last vaccination)

____

____

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

- ☐ Bad Breath
- ☐ 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
- ☐ Sneeezing
- ☐ Thirst and/or Urination Increased
- ☐ Vomiting
- ☐ Weakness
- ☐ Weight Problem
- ☐ Other ______________________________

Current medications:

____

____

Pet's Name ______________________________ Date of Birth ______________

Species: ___ Dog ___ Cat ___ Other (please specify) ______________________________

Sex: ___ Male ___ Neutered ___ Female ___ Spayed

Breed: ____________________ Color: ____________________ Weight ____________

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- ☐ Thirst and/or Urination Increased
- ☐ Vomiting
- ☐ Weakness
- ☐ Weight Problem
- ☐ Other ______________________________

Current medications:

____

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