

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

Registration

Date \_\_\_\_\_ Driver's Lic. # \_\_\_\_\_  
 Name \_\_\_\_\_ Employer/Occupation \_\_\_\_\_  
 Spouse \_\_\_\_\_ Employer/Occupation \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_  
 E-mail address (if you would prefer reminders sent by email) \_\_\_\_\_  
 Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_  
 How did you learn about our clinic?  Yellow Pages  Recommendation  Web Page  
 Sign/Location  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 \_\_\_\_\_ Birth Date/Age \_\_\_\_\_  
 Male—Neutered? Yes  No  Female—Spayed? Yes  No   
**Vaccination History (Date of last vaccines)** Rabies \_\_\_\_\_  
 Feline: FVRCP (3-in-1 or 4-in-1) \_\_\_\_\_ FeLV (Leukemia) \_\_\_\_\_ Other \_\_\_\_\_  
 Canine: DHLPPC (5-in-1, 6-in-1, 7-in-1) \_\_\_\_\_ Bordatella \_\_\_\_\_  
 Current medications \_\_\_\_\_

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 Bulging or Bloodshot	<input type="checkbox"/> Seems Depressed	_____
<input type="checkbox"/> Gagging	<input type="checkbox"/> Shaking Head	_____

Where did you get this pet? \_\_\_\_\_  
 How long have you had this pet? \_\_\_\_\_  
 Is this pet (circle one) *indoor only* *outdoor only* *indoor & outdoor* *other/undecided*  
*Please ask for additional pet history sheets for your other pets.*

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 \_\_\_\_\_

*We accept Cash, Check, Visa, MasterCard, and CareCredit.*