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.

Registration

Owner: ____ Date: ______________

Address: ___________________________________ City: ________________ Zipcode: ____________

Main Phone: _________________________________ Other:_______________________________

Email: ____

Spouse/Relative/Other Name: ______________________________ Phone: _______________________

Previous Veterinarian for Records: ____

Groomer/Boarding/Other who is allowed to access your pet records? ☐ Yes ☐ No

If yes who– Name(s):____

How did you hear about our clinic? ☐ Google ☐ Facebook ☐ Sign ☐ Recommendation ☐ Other: ________________

If recommended, by whom? ____

Reason for Visit? ____

Pet Health History

Name of Pet: ____ ☐ Dog ☐ Cat

Breed: _____________________________ Color: ______________________ Birthdate: ____________

Is your pet: ☐ Male ☐ Female Is your pet spayed/neutered? ____________

Pets Current Medications/Preventatives: ____

List Pet Food/Treats: ____

Any Allergies /Allergic Reactions/Diagnosed Conditions?: ____

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

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

Authorization

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