

Welcome

Date _____

Time _____

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

Owner _____ SS# _____
Address _____

Spouse _____ SS# _____
Home Phone _____ Work Phone _____ Cell Phone _____
Emergency Contact Name _____ Phone _____
Email address _____

How did you learn about our hospital?

- Yellow Pages
- Recommendation
- Sign
- Other _____

If recommended by whom? _____

Number of pets: Dogs _____ Cats _____ Other (specify) _____

Reason for visit _____

Pet Health History

Name of pet _____

- Dog
- Other _____
- Cat

Breed _____ Color _____ Birthdate _____

- Male
- Male Neutered
- Female
- Female Spayed

Vaccination History (Date and Type of last vaccination) _____

Please circle any symptoms of problems that you have noticed about your pet:

Behavior Problems	Bleeding Gums	Breathing Problems
Coughing	Diarrhea	Eye Bulging or Blood shot
Gagging	Lack of Appetite	Limping
Loss of Balance	Scotting	Scratching
Seems Depressed	Shaking Head	Sneezing
Vomiting	Weakness	Thirst and/or Urination increase

Other _____

Pet's Current medication: _____

Describe your pet's diet _____

Primary Veterinarian _____

Authorization

I understand that I assume financial responsibility for all services rendered and that full payment is due upon discharge. I will be paying in the form of:

- Cash
- Check
- Credit Card

Signature of Owner or Responsible agent: _____