



Welcome

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you may 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: _____ Co-Owner: _____
Address: _____ City: _____ Zip: _____
Owner Primary #: _____ Co-Owner Primary #: _____
E-Mail: _____ In case of an emergency, please call: _____
Please describe other animals in the household: _____
Reason for visit today: _____

PET HEALTH HISTORY

Pet's Name: _____ Date of Birth: _____
Type of Animal: Dog ___ Cat ___ Sex: Male ___ Female ___ Neutered/Spayed ___
Breed: _____ Color: _____ Last Known Weight: _____

Please Check Any Symptoms or Problems 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"/> Increase in Thirst or Urination
<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"/> Weight Problem
<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Seems Depressed	<input type="checkbox"/> Gagging
<input type="checkbox"/> Shaking Head	Other: _____	

Current Medications or Chronic Medical Conditions, If Any: _____

Describe Your Pet's Diet: _____
Allergies to Medications, Food or Vaccines? _____

REFERRALS

How did you hear about us? _____
If you were referred by someone, who may we thank for the referral _____

May we call your previous Veterinarian for your pet's medical records? _____

Vet's Name: _____ Phone: _____

FINANCIAL POLICY

We require full payment at the time services are rendered. We accept cash, checks*, Visa, Mastercard, Discover, American Express and Care Credit.

If you plan to pay by check, we ask that you also provide the following information:

Driver's License # _____

*All checks are subject to bank approval. Any returned checks are subject to a \$25.00 returned check fee and must be resolved in cash, Credit Card or Cashier's Check.

CONSENT FOR SERVICES

SIGNATURE: _____ DATE: _____