Welcome

Thank you for giving us the opportunity to care for your pet. We will be happy to answer any questions you have about your pet's health. Please take a few moments to read and fill out form completely. Thank you.

Registration

Date: _____

Owner: _____

Address: _____ **City:**_____ **Zip:** _____

Drivers License: state & number: _____

Spouse: _____

E-Mail Address: _____

Would you like to receive special offers through email: yes_____ no _____

Contact numbers: please indicate home, cell, work, etc.

Primary: _____ **Secondary:** _____

Other(s):_____

Emergency contact name & phone: _____

_____

How did you learn of our hospital? ___ Yellow Pages ___ Internet ___ Sign

___ Recommendation, if so, by whom _____

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

Reason for visit: _____

Pet Health History

Pet Name: _____ **Dog _____ Cat _____**

Breed: _____ **Color:** _____ **D.O.B.** _____

____ Male Intact _____ Male Neutered _____ Female Intact _____ Female Spayed

Vaccination History (date & type of last vaccines)_____

_____

Please check signs or problems that you may have noticed about your pet:

___Behavior ___Change in appetite ___Sneezing ___Bleeding gums ___Limping

___ Thirst and/or urination increased ___Breathing Problems ___ Loss of balance

___ Vomiting ___ Coughing ___Scooting ___Weakness ___ Diarrhea ___Scratching

___ Gagging ___ Seems Depressed ___ Shaking Head ___Eye Problems

___ Other: _____

Pet's current medications: _____

Diet (Brand, Dry/Can) _____

Authorization

I hereby authorize the veterinarian and hospital staff to examine, prescribe and/or treat above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that all charges will be paid in full at time of release. If pet is hospitalized or requires surgical treatment an initial payment will be required. I understand that there is a return check policy and that I will be charged a fee of $35.00 if my check is returned. I agree to pay a reasonable fee for collection in the event that collection efforts become necessary, and/or attorney fees that are compiled by clinic in securing unpaid balances.

PAYMENT IN FULL IS DUE AT THE TIME SERVICES ARE RENDERED

Method of Payment: ___ Cash ___ Check ___Visa ___M/C ___AMX ___ Discover

___ Care Credit ___ Other: _____

Signature of Owner_____