



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 ensure the best care possible, please take the time to fill out this form. Thank you!

**REGISTRATION**

Owner \_\_\_\_\_ Spouse/ Other \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse/ Other Phone \_\_\_\_\_

Email (for healthcare reminders) \_\_\_\_\_

**Emergency Contact Name and Number** \_\_\_\_\_

How did you learn of our clinic?     Phone Book     Internet     Drive by     Recommendation  
 Other \_\_\_\_\_

If recommended, whom may we thank? \_\_\_\_\_

**PET HEALTH HISTORY**

Name of pet \_\_\_\_\_     Dog     Cat     Other \_\_\_\_\_

Breed \_\_\_\_\_ Color \_\_\_\_\_ Age/ Birth date \_\_\_\_\_

Male     Neutered     Female     Spayed

Previous veterinarian (if applicable): \_\_\_\_\_

Pet's current medications and diet: \_\_\_\_\_

Vaccination History (date and type of last vaccinations): \_\_\_\_\_

**REASON FOR VISIT (problems and/or symptoms):** \_\_\_\_\_

**PUT ADDITIONAL PETS ON BACK OF FORM**

**AUTHORIZATION**

I hereby authorize to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal(s). 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** \_\_\_\_\_

**Method of payment**     Cash     Check     VISA     Master Card     Other

**If you are paying with a check, you MUST provide a Drivers License or State ID to be photo copied.**

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Breed \_\_\_\_\_ Color \_\_\_\_\_ Age/ Birth date \_\_\_\_\_

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Vaccination History (date and type of last vaccinations): \_\_\_\_\_

**REASON FOR VISIT (problems and/or symptoms):** \_\_\_\_\_

\_\_\_\_\_

**PET HEALTH HISTORY**

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Breed \_\_\_\_\_ Color \_\_\_\_\_ Age/ Birth date \_\_\_\_\_

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**REASON FOR VISIT (problems and/or symptoms):** \_\_\_\_\_

\_\_\_\_\_