



REGISTRATION

Date _____

Owner _____

SS# _____

Address _____

DL# _____ Exp: _____

City _____ State ____ Zip _____

Spouse _____ SS# _____

Home Phone _____ Work Phone _____

Emergency Contact _____ Phone _____

Number of pets ____ Dogs ____ Cats ____ Others _____

Reason for visit

PET HEALTH HISTORY

Name of pet _____ Dog ____ Cat ____

Other _____ Breed _____

Color _____ Birthdate _____ / Age ____

Male ____ Neutered? ____ Female ____ Spayed? ____

Vaccination History (Date and type of last vaccinations) _____

Please circle any symptoms or problems that you have noticed about your pet.

Behavior Problems

Bleeding Gums

Coughing

Diarrhea

Eye Bulging or Bloodshot

Gagging

Limping

Loss of Balance

Scotting

Scratching

Seems Depressed

Shaking Head

Sneezing

Thirst and/or Urination Increased

Vomiting

Weakness

Other (Please Explain)

Pet's Current Medications

Describe your pet's diet (type and brand of food)

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in 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 _____

Method of payment; Cash___ Check___ Master Card___ Visa___ Other _____

