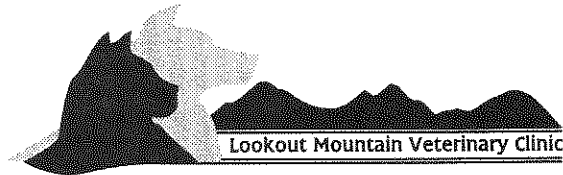


# PET REGISTRATION AND HISTORY



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!

Date \_\_\_\_\_

## REGISTRATION

Owner \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse/Partner \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

How did you learn of our clinic?  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  Cat  Other \_\_\_\_\_

Breed \_\_\_\_\_ Color \_\_\_\_\_ Birthdate or Age \_\_\_\_\_

Male  Neutered  Female  Spayed

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

Please check (✓) any symptoms or problems that 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"/> Thirst and/or Urination Increased |
| <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"/> Other _____                       |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Seems Depressed  | _____  |
| <input type="checkbox"/> Gagging                  | <input type="checkbox"/> Shaking Head     | _____  |

Pet's current medications \_\_\_\_\_

Describe your pet's diet \_\_\_\_\_

## AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above pet. I assume responsibility for charges incurred in the care of this animal. I also understand that these charges will be paid at time of release and a deposit may be required for surgical treatment.

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_