

Number of Pets: Dogs _____ Cats _____ Other _____

Name of Previous Veterinarian/Hospital _____

Phone : _____

Please check any symptoms or problems you may have noticed about your pet:

- Behavior problems Lack of appetite Sneezing Bleeding gums
- Limping Vomiting Coughing Loss of balance
- Breathing problems Diarrhea Scooting Shaking head
- Scratching Weakness Increased thirst or urination
- OTHER _____

Pet Registration:

Pet #1 Name _____ Species: Dog _ Cat _ Other _____

Breed: _____ Color: _____ Birth Date: _____

Sex: Female _ Male _ Spayed/Neutered Yes _ No _ At what age? _____

Cats only! Please circle appropriate answer Indoor/Outdoor? Declawed?

List your pets current medications _____

Does our staff need to be aware of any medical history/behavior? _____

Date of last rabies vaccination? _____ Other vaccines up to date? Y _ N _

Pet #2 Name _____ Species: Dog _ Cat _ Other _____

Breed: _____ Color: _____ Birth Date: _____

Sex: Female _ Male _ Spayed/Neutered Yes _ No _ At what age? _____

Cats only! Please circle appropriate answers Indoor/Outdoor? Declawed?

List your pets current medications _____

Does our staff need to be aware of any medical history/behavior? _____

Date of last rabies vaccination? _____ Other vaccines up to date? Y _ N _

Pet #3 Name _____ Species: Dog _ Cat _ Other _____

Breed: _____ Color: _____ Birth Date: _____

Sex: Female _ Male _ Spayed/Neutered Yes _ No _ At what age? _____

Cats Only! Please circle appropriate answers Indoor/Outdoor? Declawed?

List your pets current medications _____

Does the staff need to be aware of any medical history/behavior? _____

Date of last rabies vaccination? _____ Other vaccines up to date? Y _ N _

Authorization

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet(s). I assume full responsibility for all charges incurred in the care of these pets. I fully understand that payment is expected at the time services are rendered, And that all charges will be paid in full at the time of visit or discharge
A deposit will be required for all emergency and surgical treatment.

Signature of Owner/Spouse/Authorized agent: _____

Method of Payment: _Cash _Check _Credit Card Visa/Mastercard