

WELCOME!

Thank you for giving us this opportunity to care for your pet. Please help us meet your needs better by taking a moment to fill out

Owner's name _____ (circle one) Mr. Mrs. Ms. Miss
Spouse/Joint owner name _____
Address _____ City _____ State _____ Zip code _____
Home phone _____ Cell phone _____ Work phone _____
Driver's license # _____ State _____ S.S. number _____
Employer name and address _____
Emergency name and number _____
Email address _____ Senior Citizen Discount (65 or older) ____ Yes ____ No
How did you first hear about this Hospital? ____ Newspaper ____ Radio ____ Welcome Wagon ____ Yellow Pages
____ Hospital Sign ____ Individual (name) _____ Web Site _____

PET HEALTH HISTORY

Pet's name _____ Birthday _____ Or age _____
Type of pet: ____ Dog ____ Cat Other _____ Breed _____
Color _____ Weight _____ Male: ____ Neutered ____ Female: ____ Spayed
Vaccination history (type of vaccine and date given) _____

Has your pet had: ____ Heartworm test ____ Lyme test ____ Fecal exam ____ Dentistry
____ Feline Leukemia/FIV test ____ Received a blood donation

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"/> Bleeding gums |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Coughing | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Eye bulging or bloodshot | <input type="checkbox"/> Limping |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Scooting | <input type="checkbox"/> Seems depressed |
| <input type="checkbox"/> Shaking head | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Increased urination |
| <input type="checkbox"/> Excessive drinking | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Weight problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Skin problems | |

OTHER PROBLEMS AND/OR CURRENT MEDICATIONS _____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume the responsibility for all charges incurred in the care of this animal. **FULL PAYMENT IS REQUIRED AT THE TIME OF EACH VISIT, THERE IS NO BILLING.** We accept Cash, Visa, Master Card, Amex, Discover, Care Credit, and Checks with a driver's license. We will gladly prepare an estimate if you desire.

(PLEASE SIGN)

(TODAY'S DATE)