Welcome

Thank you for giving us the opportunity to care of your pet at Family Pet Hospital. To insure the best possible care, please complete this form to the best of your knowledge. We will be happy to answer any questions you have about your pet's health.

Registration

Date _____

Owner: _____ DL #: _____

Email: _____ Cell #: _____

Address: _____

City: _____ State: _____ Zip: _____

Spouse: _____ Cell #: _____

Home Phone: _____ Work Phone: _____ Spouse Work Phone: _____

Emergency Contact Number: _____

How did you learn of our clinic? ❑ Yellow Pages ❑ Recommendation

❑ Sign ❑ Other _____

If recommendation, by whom? _____

Number of pets: Dogs _____ Cats _____

Reason for visit _____

Pet Health History

Name of Pet _____ ❑ Dog ❑ Cat ❑ Other _____

Breed _____ Color _____ Birthdate _____

❑ Male ❑ Neutered ❑ Female ❑ Spayed

Vaccination History (Date and type of last vaccination) _____

_____

_____

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

❑ Behavior Problems
❑ Breathing Problems
❑ Coughing
❑ Diarrhea
❑ Eye Bulging or
❑ Gagging
❑ Lack of Appetite
❑ Loss of Balance
❑ Scooting
❑ Scratching
❑ Seems Depressed
❑ Shaking Head
❑ Sneezing
❑ Thirst and/or Urination increase
❑ Vomiting
❑ Weakness
❑ Other

Pet's current medications: _____

_____

Describe your pet's diet: _____

_____

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 ❑ MasterCard ❑ VISA ❑ Other _____