Welcome

to our Clinic

Date:____/____/____

Owner's Name:_____

Address:_____

City: _____ State: _____ Zip:_____

Birthdate: ____/___/___ Phone: (__) _____ Email: _____

Employer:_____ Work Phone: (__) _____

Emergency Contact Name: _____ Phone: (__) _____

Number of Pets (please specify type): _____

Pet Health History:

Pets Name:_____ Age:_____

Type:_____ Breed:_____ Color:_____

Sex: M❑ F❑ Neutered/Spayed: Y❑ N❑ Date: ___/____/____

Current medications your pet is taking:_____

_____

Vaccination History:

❑ Distemper Date:___/___/__ ❑ Parvovirus Date:___/___/__ ❑ Rabies Date:___/___/__

Primary reason for visit: _____

Symptoms your pet is demonstrating:

❑ Appetite Loss	❑ Diarrhea	❑ Loss of Balance	❑ Thirst
❑ Behavioral Changes	❑ Eye Disorders	❑ Scooting	❑ Urination Increase
❑ Breathing Problems	❑ Gagging	❑ Scratching	❑ Vomiting
❑ Coughing	❑ Gums Bleeding	❑ Shaking head	❑ Weakness
❑ Depression	❑ Limping	❑ Sneezing	❑ Other:_____

Prior Surgeries:_____

Prior Illnesses: _____

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 the animal. I also understand that all professional fees are due at the time services are rendered.

Signature of responsible party_____ Date:___/___/___

The information on this form is strictly confidential and is to be used only by this practice to provide care and treatment for your pet.