CLIENT REGISTRATION

Owner's Name: Last______________________________ First________________________

Address ___________________________________ City______________________ State________ Zip_________

Home # ______________________ Cell or Pager #_________________ Employer______________ Work #__________

Spouse's Name______________________ Spouse's Employer_____________________ Work #_________________

How did you learn of our hospital?

☐ Website ☐ Google

☐ Yellow Pages ☐ Recommendation If so, who may we thank? ___________________

PET INFORMATION

Name of Pet_______________________

☐ Dog ☐ Cat ☐ Other _____________ ☐ Male ☐ Neutered
☐ Female ☐ Spayed

Breed_________________________ Color___________________
Birth Date__________________

Vaccination History (Date and type of last vaccinations) ____

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

☐ Behavior Problems	☐ Lack of Appetite	☐ Sneezing	☐ Bleeding Gums
☐ Limping	☐ Breathing Problems	☐ Loss of Balance	☐ Vomiting
☐ Coughing	☐ Scooting	☐ Weakness	☐ Diarrhea
☐ Scratching	☐ Gagging	☐ Depressed	☐ Shaking Head
☐ Eyes Bulging/Bloodshot	☐ Thirst and/or Frequent Urination		

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 full responsibility for all charges incurred in the care of this animal. I also understand that these charges incurred will be paid at the time services are rendered.

Signature of Owner____ Date _________________

Method of Payment: ☐ Cash ☐ Check ☐ Mastercard ☐ Visa

For Office Use Only

Canine			**Feline**		
Rabies	1yr	3yr	Rabies (Purevax 1year)		
Distemper/Parvovirus	1yr	3yr	Rhino/Calici/Panleukopenia	1yr	3yr
Bordetella	6mo	1yr	Leukemia		
Leptospirosis			FIV		
Lyme					