



WELCOME

Thank you for giving us the opportunity to care for your pet. We will be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank You!

REGISTRATION

OWNER: _____	SPOUSE'S NAME: _____	
MAILING ADDRESS: _____		
CITY: _____	ST: _____	ZIP: _____
PRIMARY PHONE # _____	SECONDARY PHONE # _____	
EMAIL ADDRESS: _____		
How did you learn about our clinic?		
<input type="checkbox"/> Online Search <input type="checkbox"/> Clinic Sign <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Recommendation <input type="checkbox"/> Other		

PATIENT INFORMATION

	PET # 1	PET # 2	PET # 3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX			
SPAYED OR NEUTERED			
Does your pet have a microchip?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for visit? _____			
Did you bring a copy of your pet's previous vaccination record? _____			
If not, where did he/she last get vaccinated? _____ clinic# _____			
Any previous serious illness or surgeries? _____			
Any allergies to vaccinations or medications? _____			
List your pet's current medication? _____			

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: _____

Circle Method of Payment: Cash Check Mastercard Visa Discover Debit American Express

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED