

Welcome

Thank you for giving us the opportunity to care for your pet. We'll 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!

		REGIST	RATION							
Owner (Last name first)					Date					
Address										
E-mail Address										
					Cell Phone					
					Phone					
E-mail Address										
Emergency Contact Name					Phone_					
How did you learn of our clinic?		☐ Website		☐ Phone Directory						
If recommended, by whom?										
Number of pets: Dogs					Other (specify)					
		ET HEALT			34 34					
				• • •						
Name of pet			g 🗌 Cat							
Breed	Color_			E	Birthdate					
Please check (✓) any symptoms or	problems that yo	ou have with you	ır pet.		2					
 □ Behavior Problems □ Bleeding Gums □ Breathing Problems □ Coughing □ Diarrhea □ Eyes Bulging or Bloodshot □ Gagging 	Lack of Appetite Limping Loss of Balance Scooting Scratching				 ☐ Sneezing ☐ Thirst and/or Urination Increased ☐ Vomiting ☐ Weakness ☐ Other 					
Pet's current medications										
Describe your pet's diet										
		AUTHOR	IZATION	:4	ia ia	*	**	:4	20	
I hereby authorize the veterinarian incurred in the care of this animal. required for surgical treatment.	to examine, pres	scribe for, or tre	at the above	described	pet. I assume time of release	e respo	nsibility that a c	for all c deposit r	harges	
Signature of Owner					Date					
Method of Payment:	Check	☐ MC®/VIS	A® Dis	cover®	☐ AmEx		Other			

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