



New Client Registration

Client Information

Owner: _____ Date: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Spouse: _____
 E-Mail Address: _____ Spouse E-mail Address: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Spouse Cell Phone: _____ Spouse Work Phone: _____
 Emergency Contact Name: _____ Phone: _____

How did you learn about our clinic? Yellow Pages Recommendation
 Sign Other

If recommended, by whom? _____
 Number of Pets: Dogs _____ Cats _____ Other (specify) _____
 Reason for Visit: _____

Pet Health History

Name of Pet: _____ Dog Cat Other _____
 Breed: _____ Color: _____ Birthdate: ___/___/___
 Gender: Male Neutered Male Female Spayed Female
 Vaccination History (Date and type of last vaccinations: _____)

Please place a check (✓) any symptoms or health issues you have noticed in your pet:

- | | | |
|--|---|---|
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Thirst/Increased Urination |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Limping | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scooting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Eye Bulging/Bloodshot | <input type="checkbox"/> Scratching | |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Shaking Head | |

Pets current medications: _____
 Describe your pet's diet: _____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for 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 a surgical treatment.

Signature of Owner/Authorized Agent: _____ Date: ___/___/___

Method of Payment: Cash Check MasterCard Visa Other _____