

## WELCOME

Thank you for giving us the oppotunity to care for your pet. We will be happy to answer any questions you may have about your pets health. To ensure the best care possible, we would like you to please take the time and fill out this form completely.

Thank you!

Address: (Street) (City, State & Zip) Home ph.:		-REGISTRATION
(City, State & Zip)  Home ph.:	Address: (Street)	
Home ph.:	(City State & Zin)	
Cell Ph.:	Home ph.:	Work ph.:
e-mail address:	Cell Ph.:	e-mail:
e-mail address:	Spouse/Partner:	SSN:
If recommended, by whom?  Reason for visit:	e-mail address:	phone:
Reason for visit:	Emergency Contact:	phone:
Name of Pet:	If recommended, by whom?_ Reason for visit:	
Vaccination History:		
Vaccination History:	Name of Pet:	CatOther:
Vaccination History:	Birth Date://	Breed:Color:
Vaccination History:	Male Neutered	Female Spayed Other pets:
Please check any symptoms or problems that you have noticed about your pet: Behavior ProblemsLack of AppetiteSneezing Bleeding GumsLimpingThirst/Urination increase Breathing ProblemsLoss of BalanceVomiting CoughingScootingWeakness DiarrheaScratchingStiffness of Joints Eye AbnormalitySeems DepressedOther GaggingShakingShaking  Pet's Current Medications:	Vaccination History:	
Behavior ProblemsLack of AppetiteSneezingThirst/Urination increaseBreathing ProblemsLoss of BalanceVomitingVomitingCoughingScootingWeaknessDiarrheaScratchingStiffness of JointsStiffness of JointsCaggingShakingShaking		
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AUTHORIZATION	· ·	. A L I T H O D I Z A T I O N

## Sorry, no Billing!

I hereby authorize the veterinarian to examine, prescribe for or treat the above described pet. I assume responsibility for all charges 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:
Signature of Owner.	Dutc.