

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 ensure the best care possible, please take the time to fill out this form completely. Thank you

REGISTRATION

Owners Name _____ Spouse Name _____

Street _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Other Phone _____

Spouse Phone _____ E-mail Address _____

How did you learn about our clinic? Yellow Page Website Sign

Other _____ Recommendation, by whom? _____

PATIENT INFORMATION

Name of pet _____ Dog Cat Male Female Spayed/Neutered? Yes No

Breed _____ Color _____ Birthdate/Age _____

For Cats only - Indoor ONLY Indoor/Outdoor Outdoor/Free Roaming

Vaccination History (Date and type of last vaccinations) _____

Is your pet Micro-chipped? Yes No Microchip Number (If known) _____

Reason for Today's Visit? Dental Consultation Exam Vaccines Other _____

Check all that apply (will only be addressed today if you elect to have an exam)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Changes in Thirst | <input type="checkbox"/> Limping | <input type="checkbox"/> Shaking head |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pain | <input type="checkbox"/> Stumbling |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Eye Concerns | <input type="checkbox"/> Scratching/Itching | <input type="checkbox"/> Urination Problems |
| <input type="checkbox"/> Appetite Change | <input type="checkbox"/> Ear Concerns | <input type="checkbox"/> Scooting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Lethargic | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Weight Loss |

Other/Describe _____

Please list current medications/Supplements _____

Please list any major medical history/allergies /reactions _____

Do you or have you traveled with your pet, where? _____

Has your pet ever lived outside of Spokane, where? _____

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 payment is due at the time services are provided and that a deposit may be required for surgical, hospitalization or dental treatments.

Signature of Owner _____ Date _____