

"Compassionate Pet Care at Home"



Registration

TODAY'S DATE _____

OWNER'S NAME _____ SPOUSE/OTHER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL _____

BEST METHOD OF CONTACT EMAIL H. PHONE W. PHONE C. PHONE

WHAT TIME IS IT BEST TO CALL ABOUT YOUR PET? _____ AM or PM

DESCRIBE OTHER ANIMALS IN HOUSEHOLD _____

REASON FOR VISIT _____

Pet Health History

PET'S NAME _____ DATE OF BIRTH _____

TYPE OF ANIMAL DOG CAT OTHER _____

SEX: MALE NEUTERED FEMALE SPAYED

BREED _____ COLOR _____ WEIGHT _____

VACCINATIONS (Date and type of last Vaccination) _____

Please **check** any symptoms or problems that you have noticed about your pet

Bad Breath	Lack of Appetite	Thirst and/or Urination increased
Behavioral Problems	Limping	Vomiting
Bleedings Gums	Loss of Balance	Weakness
Breathing Problems	Scotting	Weight Problem
Coughing	Scratching	Other _____
Diarrhea	Seems Depressed	_____
Eye Bulging or Bloodshot	Shaking Head	_____
Gagging	Sneezing	_____

CURRENT MEDICATIONS _____

DESCRIBE YOUR PET'S DIET _____

Consent

I hereby authorize the Veterinarian to examine, prescribe for or treat the above described pet. I assume full responsibility for all charges incurred in the care of this animal. I understand that these charges must be paid at the time of service.

Signature of Owner/Agent _____ Date _____

Method of payment Cash Check MasterCard Visa Debit