APOLLO NORTH ANIMAL HOSPITAL

REGISTRATION FORM

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!

Owner: _____ Spouse/Co-Owner:_____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____

E-mail Address: _____ Spouse/Co-Owner Cell: _____

How did you hear about Apollo North?

	Existing Client		Building Sign		Drive By		Referred by:
	Facebook		Website/Internet		Yellow Pages		

Number of pets in household: Dogs _____ Cats _____ Birds _____ Reptiles _____ Other _____

Reason for visit: _____

PET HEALTH HISTORY

Name of Pet: _____ Dog ____ Cat ____ Bird ____ Reptile ____ Other _____

Breed: _____ Color: _____ DOB/Age: _____

Male ____ Neutered ____ Female ____ Spayed ____ Is your pet currently Microchipped? Yes ____ No ____

Vaccination History (Date and type of last vaccinations): _____

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

	Bad Breath		Ear Problems		Lack of Appetite		Shaking Head
	Behavior Problems		Eye Bulging or Bloodshot		Limping		Sneezing
	Bleeding Gums		Gagging		Loss of Balance		Straining to Urinate
	Breathing Issues		Hair Loss/Bald Patches		Scooting		Vomiting
	Coughing		Increased Thirst/Urination		Scratching		Weakness
	Diarrhea		Inappropriate Urination		Seems Depressed		Weight Loss/Gain

Pet's current medications _____

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 pet. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. Delinquent accounts will be charges 1.5% per month and subject to collections.

Signature of Owner:_____Date:_____