WELCOME

Thank you for giving us the opportunity to care for your pet. We will 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!

REGISTRATION

Date: _____

Owner's Last Name: _____First:_____ ☐Mr. ☐ Mrs. ☐ Ms.
Address: _____ City/State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Referral: _____
SS #: _____ DL #: _____ Email: _____
Co-Owner: _____ SS #: _____ DL #: _____
Reason for Visit: _____

PET HEALTH HISTORY

Name of Pet: _____ ☐ Male ☐ Neutered ☐ Female ☐ Spayed
Birthday: _____ Breed: _____ Color: _____
☐ Dog ☐ Cat ☐ Other: _____
Vaccination History (Date and/or last Veterinary Clinic): _____

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

☐ Thirst and/or Urination Increased	☐ Coughing	☐ Bleeding Gums
☐ Behavior Problems	☐ Diarrhea	☐ Vomiting
☐ Breathing Problems	☐ Eye Bulging or Blood Shot	☐ Scooting
☐ Seems Depressed	☐ Lack of Appetite	☐ Scratching
☐ Sneezing	☐ Loss of Balance	☐ Weakness
☐ Limping	☐ Shaking Head	☐ Gagging

☐ Other: _____

Pet's Current Medications: _____

Describe your pet's diet: _____

AUTHORIZATION

I herby authorize the Veterinarian to examine, prescribe for and/or treat the above-described pet. I assume full responsibility for all charges incurred by my pet while under the care of St. Francis of Assisi VMC. I also understand that all charges will be paid at the time of release and that a deposit may be required for treatment.

Signature of Owner: _____

Method of Payment ☐ Cash ☐ Check ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover ☐ Care Credit