



WELCOME

We know your pet's health is important and we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form completely. Thank You!



REGISTRATION

Date _____

Owner _____

Address _____

Spouse _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact Name _____ Phone _____

How did you learn about our clinic? Yellow Pages Recommendation
 Sign Other _____

If recommended, by whom? _____

Number of pets: Dogs _____ Cats _____ Other (Specify) _____

Reason for visit _____



PET HEALTH HISTORY

Name of pet _____ Dog Cat Other _____

Breed _____ Color _____ Birthdate _____

Male Neutered Female Spayed

Vaccination History (Date and type of last vaccinations) _____

Please check (✓) any symptoms or problems that you have noticed about your pet.

- | | | |
|---|---|--|
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Limping | <input type="checkbox"/> Thirst and/or Urination Increased |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Scooting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Seems Depressed | |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Shaking Head | |

Pet's current medications _____

Describe your pet's diet _____



AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for 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 _____

Method of payment Cash Check MasterCard Visa Other _____

I, the undersigned, do hereby certify that I am the owner (duly authorized agent for the owner) of the animal (s) described below. I hereby give to the doctors of the Belleville Animal Clinic and their staff permission to release any and all medical information pertaining to the animal (s) described below. For boarding, grooming, training purposes or other.

Name (s) of Animals _____

Signature of owner _____ Date _____