REGISTRATION:

FIRST NAME:_____ LAST NAME:_____ SPOUSE/OTHER:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK:_____ CELL:_____

E-MAIL ADDRESS:_____

HOW DID YOU HEAR ABOUT US?_____

PET HEALTH HISTORY:

1) PET'S NAME:_____DATE OF BIRTH/AGE:_____

TYPE OF ANIMAL: ( ) DOG ( ) CAT ( ) OTHER

SEX: ( ) MALE ( ) NEUTERED ( ) FEMALE ( ) SPAYED

BREED:_____COLOR:_____

VACCINE HISTORY (TYPE AND DATE GIVEN):

_____

2) PET'S NAME:_____DATE OF BIRTH/AGE:_____

TYPE OF ANIMAL: ( ) DOG ( ) CAT ( ) OTHER

SEX: ( ) MALE ( ) NEUTERED ( ) FEMALE ( ) SPAYED

BREED:_____COLOR:_____

VACCINE HISTORY (TYPE AND DATE GIVEN):

_____

PLEASE CIRCLE ANY SYMPTOMS OR PROBLEMS YOU HAVE NOTICED IN YOUR PET:

-BAD BREATH	-SHAKING HEAD	-INCREASED URINATION	-SCOOTING
-BEHAVIOR PROBLEMS	-LOSS OF BALANCE	-WEAKNESS	-SNEEZING
-BLEEDING GUMS	-LOSS OF APPETITE	-WEIGHT PROBLEM	-LIMPING
-BREATHING PROBLEMS	-COUGHING	-VOMITING/DIARRHEA	-SCRATCHING

AUTHORIZATION

I hereby authorize the Veterinarian to examine, prescribe for, and treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I understand that all charges are due at the time of service.

SIGNATURE:_____ DATE:_____