

REGISTRATION

Owner's Name _____ Drivers License # _____ Exp. Date _____

Address _____ City _____ State _____ Zip Code _____

Spouse/Co-Owner's Name _____ Drivers License # _____ Exp. Date _____

Home Phone _____ E-Mail Address _____

Owner Work Phone _____ Spouse/Co-Owner Work Phone _____

Emergency Contact Name & Phone _____

Pet Name _____ Dog Cat Other _____

Breed _____ Color _____ Age/DOB _____

Male Female Neutered/Spayed? _____ If so, when? _____

Has your pet ever had an I.D. microchip implanted? _____ If so, type & registration #? _____

PET HEALTH HISTORY

Has your pet been seen previously by a Veterinarian for vaccinations or medical treatment? _____ If so, may we obtain records? _____ Name of Clinic or Veterinarian _____ City/State _____

Reason for today's visit? _____

Please check any Medical/Behavioral Symptoms you have noticed at home.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Lack of appetite/water intake | <input type="checkbox"/> Discharge from eyes/nose | <input type="checkbox"/> Scratching/chewing | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Activity decreased | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Shaking head | <input type="checkbox"/> Destructive behavior |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Coughing | <input type="checkbox"/> Scooting | <input type="checkbox"/> Excessive barking |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Hair loss | <input type="checkbox"/> People/animal aggressive |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Straining to urinate | <input type="checkbox"/> Skin irritation | <input type="checkbox"/> Difficulty housetraining |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Straining to defecate | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Housetrained pet urinating or defecating in inappropriate places. |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Limping | | |
| <input type="checkbox"/> Other _____ | | | |

How did you find out about Boat Club Road Animal Hospital? _____

Vaccination history (date & type of last vaccines) _____

Given by? _____

Please list your pets current medications (include heartworm & flea preventives) _____

Has your pet ever had an adverse reaction to a medication, vaccination, anesthesia, food, etc.? _____ If so, please describe. _____

Any previous serious illness or surgery? _____

Tell us about your pets diet. _____

Are there other pets in the household? _____

AUTHORIZATION

I hereby authorize the Veterinarian to examine, prescribe for, &/or treat the pet described above. I assume responsibility for all charges incurred in the care of this animal. I also understand that charges will be paid at the time of release and that a deposit may be required for extensive medical or surgical treatment.

Signature of owner _____ Date _____

Preferred method of payment: Cash Check Visa MasterCard American Express Discover
