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PATIENT REGISTRATION FORM

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer and questions you have about your pet's health. To ensure the best care possible, please take the time to fill out this form completely.

Please complete this form to the best of your knowledge.

Date: _____

Owner Name: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Spouse Name: _____ SSN: _____

Spouse Phone: _____ How did you hear about us? _____

PET HEALTH HISTORY

Name of Pet: _____ Regular Veterinarian: _____

Breed of Pet: _____ Dog Cat Other: _____ Male Female

Patient DOB/Age: _____ Weight: _____ Spayed/Neutered? Yes No

Vaccination History: _____

Reason for Visit: _____ Have you been here before? Yes No

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Weakness/Lethargy | <input type="checkbox"/> Depression | <input type="checkbox"/> Lack of Appetite |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Scooting | <input type="checkbox"/> Gagging |
| <input type="checkbox"/> Limping | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Scratching | <input type="checkbox"/> Bulging/Bloodshot Eyes | <input type="checkbox"/> Sneezing |

Please describe the symptoms checked above or any other issues: _____

Pet's Current Medications: _____

Pet's Current Diet: _____

AUTHORIZATION

The undersigned owner or agent hereby acknowledges that the care which is (or was) furnished to this animal by the Animal Emergency and Specialty Center will be (or was) limited to treatment, and that the Center has no facilities for boarding. I hereby authorize any treatment including the administration and performance of a surgical procedure which the Clinic deems necessary.

I further understand that I am responsible for professional and clinic fees, including the fees for medicines and diagnostic procedures and that this responsibility continues in the event that the patient fails to recover or is disposed of. I, the Owner/Agent, understand that I am responsible for complete payment of the charges upon release of the patient. I will be responsible for any collection of legal fees if the bill is not paid. It is also expressly understood and agreed that I will pick up my animal in a timely manner when discharged unless other arrangements have been made. Upon my failure to pick up the animal at this time, the Center is hereby empowered at its sole discretion to transport the animal at the owner's expense to the referring or selected hospital, or in any other manner dispose of my animal. The Center is released and forever discharged from any and all liability for acts of matters taken by it in connection with my animal's disposal. I am aware that I am under audio and video surveillance and consent to the use thereof. **A deposit is required before treatment can be initiated; payment is required when services are rendered (no credit).**

Signature of Owner/Agent _____ Date _____

Method of Payment: Cash Check Visa MasterCard American Express Discover Other: _____