



# Welcome

Thank you for giving us the opportunity to care for your pet. We'll 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

Human's Name \_\_\_\_\_ Spouse / Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other \_\_\_\_\_

Email Address \_\_\_\_\_

In Case of Emergency Please call: Name: \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us?  Drive by  Yellow Pages  Advertisement  Person, Who? \_\_\_\_\_

## Pet Health History

Pet's Name \_\_\_\_\_ Date of Birth/Approx. Age \_\_\_\_\_

Type of Animal  Dog  Cat  Guinea Pig  Ferret  Hamster  Other \_\_\_\_\_

Sex:  Male  Female  Neutered Male  Spayed Female

Breed \_\_\_\_\_ Color \_\_\_\_\_

Microchipped  Yes  No

Current Heartworm preventative, flea preventative, and Medications: \_\_\_\_\_

Describe your Pet's Diet \_\_\_\_\_

Previous Veterinarian \_\_\_\_\_ Phone \_\_\_\_\_

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bad Breath         | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Increased Thirst        |
| <input type="checkbox"/> Bleeding Gums      | <input type="checkbox"/> Limping          | <input type="checkbox"/> Inappropriate urination |
| <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"/> Weight Problems         |
| <input type="checkbox"/> Behavior Problems  | <input type="checkbox"/> Seems Depressed  | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> Eyes Red or Itchy  | <input type="checkbox"/> Shaking Head     | _____  |
| <input type="checkbox"/> Gagging            | <input type="checkbox"/> Sneezing         | _____  |

## Authorization

I hereby authorize the Bartram Trail Veterinary Hospital to examine, prescribe for, and/or treat my pet(s). I assume responsibility for all charges incurred in the care of the animal. I understand that these charges must be paid when services are rendered and a deposit may be required for some treatments.

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_

PLEASE SEE OTHER SIDE FOR MORE PET INFORMATION

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