Welcome

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

REGISTRATION

Date ___________________________________

Owner ____ Email ____

Address ____

City ____ State ___________________ Zip ____________________

Home Phone ________________________ Cell Phone ______________________ Work Phone ______________________

Spouse ____ Email ____

Spouse Home Phone _________________ Cell Phone ______________________ Work Phone ______________________

Emergency Contact Name ____ Phone ___________________________

How did you learn about our clinic? ☐ Internet ☐ Sign ☐ Facebook ☐ Newspaper ☐ Yellow Pages
☐ Recommendation – by whom? ____

Owner authorizes NPAC to take pictures and/or videos of your pet(s) for continuing education, medical publications or promotional purposes. ***Signature*** ____

PET HEALTH HISTORY

Pet Name ____ ☐ Dog ☐ Cat ☐ Other ___________________

Breed _______________________________ Color ___________________________ Birthdate/Age ____________________

☐ Male ☐ Neutered ☐ Female ☐ Spayed

Reason for visit ____

____

Name of Previous Veterinarian/Veterinary Clinic ____

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

- ☐ Behavior Problems
- ☐ Bleeding Gums
- ☐ Breathing Problems
- ☐ Coughing
- ☐ Diarrhea
- ☐ Eye Bulging or Bloodshot
- ☐ Gagging
- ☐ Lack of Appetite
- ☐ Limping
- ☐ Loss of Balance
- ☐ Scooting
- ☐ Scratching
- ☐ Seems Depressed/Low Energy
- ☐ Shaking Head
- ☐ Sneezing
- ☐ Thirsty/Increased Urination
- ☐ Vomiting
- ☐ Weakness
- ☐ Wound
- ☐ Other___________________

Pet's current medications ____

Describe your pet's diet (type of food/amount/frequency) ____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal and understand that payment is due at the time of service. I also understand that a deposit may be required for surgical treatment.

Signature of owner ____

Method of Payment: ☐ Cash ☐ MasterCard ☐ Visa ☐ CareCredit ☐ Amex ☐ Discover