

# Welcome



Thank you.

The Monroeville Pet Hospital would like to welcome you, and to thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you may have about your pet. To ensure the best care possible, please take the time to fill out this registration form completely.

Please complete and print in all four boxes below.

Client no. \_\_\_\_\_

1. Today's Date \_\_\_\_\_

Pet Owner's Name \_\_\_\_\_  Mr.  Ms.  Mrs.  Miss.  Dr.  Other \_\_\_\_\_

& Street Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_ Other Phone# \_\_\_\_\_

Name of  Spouse or  Significant Other \_\_\_\_\_ Emergency Contact \_\_\_\_\_

& Emergency Contact# \_\_\_\_\_ Pets in household: Dogs# \_\_\_\_\_ Cats# \_\_\_\_\_ Other \_\_\_\_\_

If recommended, by whom? \_\_\_\_\_ E-mail (for reminders) \_\_\_\_\_

## PET / PATIENT HISTORY

2. Pet's Name \_\_\_\_\_  Dog or  Cat;  Male/ Neutered or  Female/ Spayed

Breed \_\_\_\_\_ Color/Markings \_\_\_\_\_ D.O.B. or Age \_\_\_\_\_

Last rabies vaccination on \_\_\_\_\_ Last distemper vaccination on \_\_\_\_\_ Other Vaccination \_\_\_\_\_

Reason for today's visit or symptoms \_\_\_\_\_

Pet's current medications \_\_\_\_\_ Known allergies \_\_\_\_\_

Pet's current diet \_\_\_\_\_

Other known medical conditions \_\_\_\_\_

Previous veterinarian's name \_\_\_\_\_ & date last seen \_\_\_\_\_

3. Check other symptoms about your pet.

Lack of appetite  Thirst increase  Scooting

Coughing  Weakness  Breathing problem

Loss of balance  Bleeding gums  Behavior

Bulging eye  Other or  None

Note \_\_\_\_\_

4. → List All Responsible Agents and Phone Numbers ←

Please list the first and last names and phone numbers of all individuals who are authorized by you to make all medical and emergency decisions for this pet. If only you will have this authority, then write "NONE".

1. (First) \_\_\_\_\_ (Last) \_\_\_\_\_ Ph# \_\_\_\_\_

2. (First) \_\_\_\_\_ (Last) \_\_\_\_\_ Ph# \_\_\_\_\_

3. (First) \_\_\_\_\_ (Last) \_\_\_\_\_ Ph# \_\_\_\_\_

## AUTHORIZATION

I 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, whether I or a Responsible Agent (as listed in box "4" above) brings the pet in for treatment. I understand that payment is due when services or property is rendered, that there is a twenty-five dollar returned check fee, and that all uncollected debts are financed at 1.5% monthly. I also understand that a deposit may be required for surgical or dental treatment. Today's payment is by (check one of the following boxes)

Cash  Check  Visa  Master Card  Other \_\_\_\_\_

Owner's/Agent's Signature \_\_\_\_\_ & Date \_\_\_\_\_

Form Recorder's Initials: \_\_\_\_\_

Monroeville Pet Hospital use only. Notes \_\_\_\_\_