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

Date__________________ Social Security #________________ E-mail__________________________

Name____

Address____ City/State/Zip__________________

Employer_________________________ Employer's Address__________________________

Spouse____ SS#______________________

Home Phone_______________ Work Phone_______________ Spouse Work Phone___________

Emergency Contact Name__________________________________ Phone_______________

How did you learn of our Hospital? ☐ Recommendation ☐ Signs ☐ Movie Theater

☐ Yellow Pages - ☐ Merrill or ☐ Wausau ☐ Other_____________________________

☐ County Market Health & Home ☐ Newspaper/Newsletter______________________

If recommended, by whom? (*We want to thank them!*) __________________________________

Pet Information

Name of pet:_________________________________ ☐ Dog ☐ Cat ☐ Other______________

Sex: ☐ Male ☐ Female Neutered/Spayed? ☐ Yes ☐ No At what age? _______________

Breed_______________________ Color_________________ Birth date__________________

What age was pet obtained? ____

From: ☐ Friend ☐ Breeder ☐ Pet Shop ☐ Humane Society ☐ Other___________________

Reason for obtaining pet (check all that apply): ☐ Companion ☐ Hunting ☐ Breeding

☐ Show ☐ Other____

Primary reason for visit:____

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

☐ Behavioral Problems/Changes
☐ Bleeding Gums
☐ Breathing Problems
☐ Coughing
☐ Diarrhea
☐ Eye Disorder:______________
☐ Gagging
☐ Lack of Appetite
☐ Limping
☐ Loss of Balance
☐ Scooting
☐ Scratching
☐ Seems Depressed
☐ Shaking Head
☐ Sneezing
☐ Increased Thirst &/or Urination
☐ Vomiting
☐ Weakness
☐ Other________________
____

List your pet's current medications:____

Describe your pet's diet:____

Pet's Vaccination & Health History (check all that your pet has received):

☐ Distemper
☐ Parvovirus (Dog)
☐ Rabies (Dog/Cat)
☐ Feline Leukemia Test
☐ FVRCP (Infectious disease- Cat)
☐ Dental
☐ Prior Surgery:________________
☐ Prior Illness:________________
☐ Other:______________________

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. I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Owner or Responsible Party____

Driver's License Number____ State_____

Method of payment: ☐ Cash ☐ Check ☐ Debit Card ☐ Credit Card ☐ CareCredit