

Welcome

Thank you 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!

OWNER REGISTRATION

OWNER (Last name first) _____ Date _____

Physical Address _____

Mailing Address (if different) _____

Email Address (for Reminders Only) _____ Owner's DL# _____

Primary Phone _____ Secondary Phone _____ Owner's D.O.B _____

SPOUSE/CO-OWNER _____ Phone _____

Email Address _____ Co-Owner's D.O.B _____

EMERGENCY CONTACT _____ Phone _____

How did you learn of our clinic? Recommendation Online Ad Phone Directory Website
 Shot Clinic Sign/Driving By Other _____

If recommended, by whom? _____

Number of pets: Dogs _____ Cats _____ Other (specify) _____

PET(S) HEALTH HISTORY

Have Your Pets Received Veterinary Care Previously? Yes No Where: _____

Please Circle Any Symptoms or Concerns You Have Regarding Your Pet(s):

Bad Breath | Behavior Problems | Bleeding Gums | Coughing | Diarrhea | Increased Thirst/Urination | Gagging
Lack of Appetite | Weight Loss/Gain | Scooting | Scratching | Shaking Head | Weakness | Loss of Balance
Seems Depressed | Limping | Vomiting | Sneezing

Do you currently use Heartworm Preventative for your dog(s)? Yes No If so, what brand _____

Do you currently use Flea Preventative for your pet(s)? Yes No If so, what brand _____

How often do you deworm your pet(s)? Monthly Annually Never Other _____

MEDICAL & PAYMENT AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat my pet(s) using the treatments she feels are most beneficial and appropriate. I further authorize the veterinarian to prescribe "extra-label" medications as medically necessary and understand that additional information will be provided if requested. I understand that no medical treatment has a guaranteed outcome. I assume responsibility for all charges incurred in the care of my pet(s). I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. For your convenience, we accept cash, checks, Visa, MasterCard, AmExw and Discover. Returned checks will be charged a \$25.00 handling fee. Balances over 30 days will be subject to a late fee of \$25.00, plus interest charges of 18% per annum.

Authorization for Photographs: I hereby authorize photographs to be taken of my pet for record-keeping at Paradise Ridge Pet Clinic.

Signature of Owner/Agent _____ Date _____