

# Welcome



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.

*Thank you.*

Please print

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

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 HISTORY

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 \_\_\_\_\_

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

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

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

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

Check any symptoms or problems about your pet.

Lack of appetite  Thirst increase  Scooting

Coughing  Weakness  Breathing problem

Loss of balance  Bleeding gums

Bulging eye  Behavior problem  Other \_\_\_\_\_

**→ Authorized Agent Only**

If you are an authorized agent for the owner, then in addition to completing blocks 1 and 2 above please complete the following.

Your Name \_\_\_\_\_

& address \_\_\_\_\_

\_\_\_\_\_

& Phone# \_\_\_\_\_

## 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. 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*

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

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

Monroeville Pet Hospital use only: (For new clients/agents paying by check or credit card)

Driver's License Name (if different from above) \_\_\_\_\_ License No. \_\_\_\_\_

Issuing State \_\_\_\_\_ Exp. \_\_\_\_\_ Address (if different from form) \_\_\_\_\_