



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 ensure the best care possible, please take the time to fill out this form completely. Thank you!

Owner(s) _____
(paying by check) DL# _____ State _____ Exp. _____ Issue Date _____
Address _____ Apt # _____
City, State _____ Zip _____
E-mail Address _____ Send E-mail Reminders
Home Phone (____) _____ - _____ cell (____) _____ - _____ Spouse cell (____) _____ - _____
Other Phone _____

Do you qualify for our active duty military discount? Military Branch: _____

How did you **first** learn about our hospital?

- DEX Yellow Pages Air Force Yellow Pages Tri-Lakes Yellow Pages Sign (drove by)
 ValPack Academy Spirit (Air Force Academy) Direct Mail Internet Search
 Recommended by _____

Number of Family Pets: Dogs _____ Cats _____ Other (specify) _____

PET HEALTH HISTORY

Pet Name _____ Dog Cat Other (specify) - _____
Breed _____ Color _____ Birth Date or Age _____

Male Neutered Female Spayed

Is your pet Microchipped? No Yes, microchip # _____

Reason for visit _____

Previous Vet _____ Vaccinations Current? Yes No

Current Medications _____

Please describe your pet's diet _____

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

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Depressed | <input type="checkbox"/> Scooting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Eye Problem | <input type="checkbox"/> Shaking Head | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Sneezing | _____ |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Limping | <input type="checkbox"/> Thirst / Urination Increased | _____ |
| | <input type="checkbox"/> Loss of Balance | | _____ |

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 these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Owner Signature _____ Date: _____