Welcome

We know your pet's health is important and we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form completely. Thank You!

Registration

Owner: _____ **Date:** _____ **Time:** _____
Address: _____
Primary Phone: _____ **Secondary Phone:** _____ **Email:** _____
Driver's License Number: _____ **State:** _____
Secondary Contact Name: _____ **Phone:** _____
Reason for Visit: _____

Pet Health History

Name of Pet: _____ ☐ Dog ☐ Cat ☐ Other: _____
Breed: _____ **Color:** _____ **Birthdate:** _____
Sex: ☐ Undetermined ☐ Male ☐ Neutered ☐ Female ☐ Spayed
I have provided the following: ☐ Vaccination History ☐ Medical History ☐ List of Medications
Previous Veterinarian Where Records Can be Obtained From (Name and Phone): _____
☐ **I authorize APAWS Veterinary Hospital team members to call for records on my behalf.**

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

☐ Behavioral Problems	☐ Lack of Appetite	☐ Sneezing
☐ Bleeding Gums	☐ Limping	☐ Thirst and or Urination Increased
☐ Breathing Problems	☐ Loss of Balance	☐ Vomiting
☐ Coughing	☐ Scooting	☐ Weakness
☐ Diarrhea	☐ Scratching	☐ Other: _____
☐ Eye Bulging or Bloodshot	☐ Seems Depressed	☐ Other: _____
☐ Gagging	☐ Shaking Head	☐ Other: _____

Pet's current medications/supplements: _____
Describe your pet's diet: _____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for 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.

Signature of Owner: _____ **Date:** _____

Payments Accepted: **Cash, Visa/Mastercard/Discover/American Express, CareCredit** **No checks accepted**