



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

Owner: _____ Date: _____
Address: _____ City: _____
State: _____ Zip Code: _____
Cell Phone: _____ Home phone: _____ Work Phone: _____
Spouse: _____
Cell Phone: _____ Home phone: _____ Work Phone: _____
Email (to sync records with PetDesk): _____
Emergency contact & Phone: _____
How did you hear about Us? _____
Number of pets: Dogs: _____ Cats: _____ Other (Specify): _____
Reason for visit? _____

PET HEALTH HISTORY

Name of Pet _____ Dog ___ Cat ___ Other ___
Breed _____ Color _____ Date of Birth _____
Male _____ Neutered _____ Female _____ Spayed _____
Vaccination History (Date and type of last vaccination)

Pet's current medications

Describe your pet's diet

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

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Limping | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Scooting | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Scratching | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Seems Depressed | |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Shaking Head | |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Sneezing | |
| <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Thirst &/or Urinating increased | |