

Craig Road Animal Hospital - New Client Registration



Name (last, first m.i.) _____

SS# _____ Driver's Lic. & State _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Address _____

Spouse/Co-owner _____

SS# _____ Driver's Lic. & State _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Address _____

Emergency Contact _____ **Phone** _____

How did you learn of our clinic?

Hospital Sign _____ Yellow Pages _____ Recommendation _____ Other/Individual _____

Previous animal hospital/veterinarian information

Name of clinic/doctor: _____ Address: _____

May we request copies of your pet(s) medical records? Yes No Other info we should know about your pet(s):

<p>AUTHORIZATION - I/We hereby authorize the veterinarian to examine, prescribe for, or treat my pet(s). I/We assume full responsibility for all charges incurred in the care of this/these animals. I/We also understand that these charges will be paid in full at the time of release and that a deposit may be required for certain surgical treatments or other procedures.</p> <p>Signature of Owner _____ Date _____</p> <p>Signature of Spouse/Co-owner _____ Date _____</p>

Animal Medical History (complete one column for each pet, as completely as possible)

Pet Information	1st Pet	2nd Pet	3rd Pet
Name:			
Species (dog, cat, reptile, bird, etc.):			
Breed:			
Description/Color(s):			
Date of Birth:			
Circle Sex: (F, M, Female/Spayed, Male/Neutered)	F F/S M M/N	F F/S M M/N	F F/S M M/N
Length of time owned:			
Diet (type of pet food):			
Vaccination History - Please give dates of most recent vaccinations:			
DOGS	Pet 1	Pet 2	Pet 3
Distemper			
Rabies			
Parvo Virus			
Corona Virus			
Bordatella (kennel cough)			
Lyme			
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CATS	Pet 1	Pet 2	Pet 3
Feline Distemper			
Rabies			
Feline Leukemia			
FIP			

Previous Medical History (indicate pet's name if you have more than one pet above)

Current special diet?

Currently on medication? Type?

Prior illness?

Prior surgery?

Prior urinary problem?

Allergies?

Date of last dental: