



integrative
**ANIMAL
HEALTH**
center

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 insure the best care possible, please take the time
to fill in this form completely.

Thank you!

REGISTRATION

Owner's/Guardian's name		Today's date	
Address	Town	State	ZipCode
<input type="checkbox"/> Home Phone	<input type="checkbox"/> Work Phone	<input type="checkbox"/> Cell Phone	
Please select primary phone number			
E-mail	Would you like to receive info and reminders via email? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer's Name & Address			
Spouse's/Other's Name & Address			
Best time to call about your pet?	At what time? <input type="checkbox"/> AM <input type="checkbox"/> PM	At what phone#	
In case of an emergency, please call			
How did you hear about us?		Referred by	
Please describe other animals in home			
Reason for visit			

PET HEALTH HISTORY

Pet's Name		Date of Birth	
Type of animal	<input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other		
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Neutered	<input type="checkbox"/> Female	<input type="checkbox"/> Spayed
Breed	Color	Weight	
Allergies			
Vaccination History (Date and type of last vaccinations)			
Current medications, if any			
Describe your pet's diet			

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 my animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical procedures.

Signature of Owner/Guardian	Date
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