

HOWELL MILL ANIMAL WELLNESS CLINIC

REGISTRATION FORM

Thank you for choosing our clinic for your pets. To better serve you, please complete this form.

CLIENT (OWNER) INFORMATION

OWNER: _____
HOME #: _____ WORK #: _____ CELL #: _____
ADDRESS: _____ COUNTY: _____
CITY: _____ STATE: _____ ZIP CODE: _____

PET INFORMATION

PET'S NAME: _____ SPECIES: DOG CAT BREED: _____
COLOR: _____ AGE: _____ SEX: MALE FEMALE
SPAYED/NEUTER: YES NO WEIGHT: _____ HOW LONG HAVE YOU HAD THIS PET? _____
HOW DID YOU OBTAIN THIS PET: _____
PREVIOUS VETERINARY CLINIC: _____

PET'S MEDICAL HISTORY PER OWNER

Has your pet had:

Comments:

- | | | | |
|---|-----|----|-------|
| 1. A rabies vaccination within the past year? | YES | NO | _____ |
| 2. Other vaccinations within the past year? | YES | NO | _____ |
| 3. Medication for a current medical problem? | YES | NO | _____ |
| 4. Any previous medical illness? | YES | NO | _____ |
| 5. Any previous injury? | YES | NO | _____ |
| 6. Contact with an animal with a known illness? | YES | NO | _____ |
| 7. A feline leukemia test or FIV test (if a cat)? | YES | NO | _____ |
| 8. Current heartworm preventative? What brand? | YES | NO | _____ |
| 9. Current flea control treatment? What type? | YES | NO | _____ |
| 10. A microchip implanted? What brand? | YES | NO | _____ |

Have you noticed any:

- | | | | |
|--|-----|----|-------|
| 11. Cough, shortness of breath, or tiring easily? | YES | NO | _____ |
| 12. Change in appetite or eating habits? | YES | NO | _____ |
| 13. Vomiting, diarrhea, or constipation? | YES | NO | _____ |
| 14. Increased thirst or excessive urination? | YES | NO | _____ |
| 15. Blood in urine, stool or other discharge? | YES | NO | _____ |
| 16. Unusual attitude, fainting or seizure? | YES | NO | _____ |
| 17. Swelling, limping, or pain on moving? | YES | NO | _____ |
| 18. Itching, hair loss, sneezing, eye/ear discharge? | YES | NO | _____ |

What brings you to the clinic today:

Would you like literature regarding 24 Petwatch Microchip Services? YES NO

Other comments: _____

I am the owner of the above pet acting as agent* for the owner and accept full financial responsibility. I give permission to proceed with any medical and/or surgical therapy, as needed, as discussed and agreed upon with the doctor.

SIGNATURE: _____ DATE: _____

*Agent of owner must note their full name, complete address, home and work telephone numbers on reverse side.

PAYMENT IS EXPECTED AT TIME OF SERVICES.