



## PATIENT REGISTRATION

Client's Name: \_\_\_\_\_

Pet's Name: \_\_\_\_\_  Dog  Cat  Other \_\_\_\_\_

Sex:  Male  Female

Neutered:  No  Yes If so, at what age? \_\_\_\_\_

DOB: \_\_\_\_\_ Breed: \_\_\_\_\_

Color/Markings: \_\_\_\_\_

Where did you get your pet from?: \_\_\_\_\_

How long have you owned your pet for?: \_\_\_\_\_

Has your pet ever been seen by a Veterinarian before? ( ) Yes ( ) No

If so, where and when? \_\_\_\_\_

Brand of food currently feeding: \_\_\_\_\_  Dry  Canned

Are table scraps given?  Yes  No

What types of treats are given? \_\_\_\_\_

List your pet's current medications and preventatives: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any special information we should know: (allergies, previous medical problems, behavioral issues)?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_