www.ParkAnimalHospital.com

203.655.7795

Thank you for giving us the opportunity to care for your pet. We will be happy to answer any questions about your pet's health. To insure the best care possible, please be sure to fill in this form completely.

PLEASE PRINT CLEARLY **Thank you!**

Client Registration

Name ________________________________ **Email Address** ______________________________________

Address ________________________________ __**City** _____________________ **Zip code** ________

Home Phone ______________________ **Cell Phone** ___________________ **Work Phone** ____________

Emergency Contact Name ______________________________ **Phone** __________________________

□ Spouse □ Significant Other □ Relative □ Friend

How did you learn of our clinic? ____

If recommended, by whom? (We would like to thank them!) _________________________________

Pet Health History

Name of pet ____ □ **Dog** □ **Cat**

□ **Male** □ **Neutered** □ **Female** □**Spayed**

Breed _________________________ **Color** _________________ **Birthday** _______________________

Reason for today's visit ____

Please check any of the following symptoms that you have noticed about your pet:

□Behavior Issues □Lethargic □Diarrhea □Shaking Head □ Eye Bulging/Blood shot
□Limping □Lack of appetite □Vomiting □ Scooting
□Loss of balance □Bleeding Gums □Sneezing □Itching/Scratching
□Gagging □Breathing Problems □Coughing □Weakness
□Other ____

Is your pet on Heartworm Preventative? Yes / No Last dose given: ________________
Is your pet on Flea/Tick Preventative? Yes / No Last dose given: ________________
Pet's Current Medications ____

Pet's diet: (brand of food) ____
Number of pets in the household: Dogs _______ **Cats** ________ **Other** (Specify) ___________________

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 this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment or hospitalization.

Signature of Owner ______________________________ **Date** __________________________________