PET REGISTRATION AND HISTORY

AADOBE ANIMAL HOSPITAL
1294 FOREST AVE
STATEN ISLAND NY 10302
(718)-370-0700

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer questions you have about your pet's health. To insure the best care possible, please take the time to fill in this for completely. Thank you!

Date__________________

PLEASE PRINT

Owner____
Adress____
_________________Zip__________________Cell Phone___________________________________
Spouse____________________________________ Work Phone____
Home Phone________________________________ E- mail____
Emergency Contact____
How did you learn about our clinic? If recommended by whom? ______________________________________
Yellow Pages Sign Other________________________________
Number of Pets: Dogs______________ Cats_______________ Other_____________________________________
Reason for visit____

PET HEALTH HISTORY

Name of pet________________________ Dog______________ Cat_______________ Other________________
Breed__________________________ Color___________________ Birth Date__________________________
Male – Neutered Y/N (Circle One) Female – Spayed Y/N (Circle One)
Last Vaccination History (if any) ____

Please check below any symptoms or problem that you have noticed:

-Behavior Problem
-Bleeding Gums
-Breathing Problems
-Coughing
-Diarrhea
-Eye Bulging or Bloodshot
-Gagging
-Lack of Appetite
-Limping
-Loss of Balance
-Scooting
-Scratching
-Seems Depressed
-Shaking Head
-Sneezing
-Thirst and / and or urination increase
-Vomiting
-Weakness
-Other___________________________
-_________________________________

Pet's Current Medications____
____
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 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. In case of any adverse reaction to any medication/ vaccination I will not hold Doctor/ Aadobe Animal Hospital responsible.

Signature of Owner____Date________________
Method of Payment__________MC__________Visa__________Dis___________Ax___________Cash