

# Porter County Pet Clinic



## Pet Registration and History

*Thank you for giving us the opportunity to treat your pets. We will be happy to answer any questions you have about your pet's health. To ensure the best care possible, please take the time to fill in this form completely.*

### Client Registration

Name \_\_\_\_\_  
(Last Name) (First Name)

For check writing privileges, please provide your SS# and/or your Driver's License # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Spouse \_\_\_\_\_ Home# \_\_\_\_\_

Work# \_\_\_\_\_ Emergency Contact Name \_\_\_\_\_

Emergency Contact # \_\_\_\_\_

How you learned of our clinic?  Yellow Pages  Sign  Recommendation  Other \_\_\_\_\_

### Pet Health History

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

Breed \_\_\_\_\_ Color \_\_\_\_\_ Birthdate \_\_\_\_\_

Male  Neutered  Female  Spayed  Unknown

Vaccine History (Date and Type of Last Vaccinations)

Please check any symptoms or problems that you have noticed concerning your pet.

- |                                       |   |  |                                     |                                     |
|---------------------------------------|---|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Behavior           | <input type="checkbox"/> Thirst Increased      | <input type="checkbox"/> Scooting   | <input type="checkbox"/> Scratching |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Bleeding Gums      | <input type="checkbox"/> Urination Increased   | <input type="checkbox"/> Scratching | <input type="checkbox"/> Weakness   |
| <input type="checkbox"/> Coughing     | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Eye Bulging/Bloodshot | <input type="checkbox"/> Limping    | <input type="checkbox"/> Depressed  |
| <input type="checkbox"/> Sneezing     | <input type="checkbox"/> Lack of Appetite   | <input type="checkbox"/> Loss of Balance       | <input type="checkbox"/> Gagging    |                                     |
| <input type="checkbox"/> Shaking Head | <input type="checkbox"/> Other _____        |  |                                     |                                     |

Pet's Current Medications \_\_\_\_\_

Pet's Current Diet (brand name, any table food?) \_\_\_\_\_

I hereby authorize the veterinarians to examine, practice 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.

Authorization Signature \_\_\_\_\_ Method of Payment  Cash  Check  Visa  MasterCard  
 Discover  CareCredit