WELCOME TO CAMPBELL PARK ANIMAL HOSPITAL

Thank you for giving us the opportunity to care for your pet. To ensure the best care possible, please take the time to fill in this form completely. Thank you!

REGISTRATION

Owner_____ DL#_____

Street_____

City_____ Zip Code_____

Spouse _____ DL#_____

Home #_____ Cell #_____ Alternate #_____

E-mail address:_____

How did you learn of our clinic? _____

If recommended, by who? _____

Number of pets: Dogs_____ Cats _____ Other (specify)_____

Reason for visit _____

PET HEALTH HISTORY

Name of Pet_____ Dog Cat Other _____

Breed_____ Color_____ Birthdate/Age _____

Circle statements that apply: Male Neutered Female Spayed

Vaccination History (Date and type given) _____

Is your pet on heartworm prevention? _____ Flea prevention? _____

Describe any chronic health problems _____

Pet's current medications _____

Describe your pet's diet _____

Has your pet been microchipped? If yes, type and number _____

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 ALL FEES ARE DUE AT THE TIME OF SERVICE AND THAT A DEPOSIT MAY BE REQUIRED.

Signature of Owner _____ Date _____