



ARLINGTON ANIMAL HOSPITAL

# Welcome

We know your pet's health is important and we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form completely. Thank You!

## REGISTRATION

Owner: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Significant Other: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Phone \_\_\_\_\_  
 How did you learn about our clinic?  Sign Outside  Yellow Pages  Facebook  Recommendation  
 Website  News Paper  Other: \_\_\_\_\_  
 If recommended, by whom? \_\_\_\_\_  
 Number of Pets Dogs: \_\_\_\_\_ Cats: \_\_\_\_\_ Other (Specify): \_\_\_\_\_  
 Reason for Visit: \_\_\_\_\_

## PET HEALTH HISTORY

Name of Pet: \_\_\_\_\_  Dog  Cat  Other: \_\_\_\_\_  
 Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Undetermined  Male  Neutered  Female  Spayed  
 Vaccination History (date and type of last vaccinations): \_\_\_\_\_

Please check (✓) any symptoms or problems that you have noticed about your pet:

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

Pet's current medications: \_\_\_\_\_  
 Describe your pet's diet: \_\_\_\_\_

## AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for 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.

Signature of Owner: \_\_\_\_\_ Date: \_\_\_\_\_  
 Method of Payment:  Cash  Check  Mastercard  Visa  Other: \_\_\_\_\_