

The Clifles Veterinary Clinic

Thank you for giving us the opportunity to care for your pet. 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 out this form completely. Thank you

REGISTRATION

Owner(s) Name: _____ Date: _____

Address (Physical and Mailing): _____

City: _____ State: _____ Zip: _____

Phone: _____ Work/Cell Phone: _____

Driver's License Number: _____ State of Issue: _____

Emergency Contact Name: _____ Phone: _____

How did you learn of our clinic: _____

Recommended by: _____

Number of Pets: _____ Cats _____ Dogs _____ Other (specify): _____

Reason for Visit: _____

PET HEALTH HISTORY

Name of Pet: _____ Dog Cat
Other _____

Breed: _____ Color: _____ Birthdate: _____

Male Neutered Female Spayed

Vaccination History (Date and type of last vaccinations): _____

Pet's current medications: _____

Brand of pet food: _____

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.

Signature of Owner: _____ Date: _____