

PET REGISTRATION AND HISTORY

MICHAEL K. JOHNS, D.V.M.

CHARLA SIMS, D.V.M.

4850 Cove Creek Dr.

Brownsboro, AL 35741

Telephone: (256) 534-7387

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

Date _____

REGISTRATION

Owner _____ Email _____

Address _____ Zip Code _____

Cell Phone _____ Home Phone _____ Work Phone _____

Spouse _____ Spouse's Work Phone _____ Spouse's Cell Phone _____

Emergency Contact Name _____ Phone _____

How did you learn of our clinic? _____ If recommended, by whom? _____

Phone Book Sign Recommendation Website Facebook

Other _____

Number of pets: Dogs _____

Cats _____

Reason for visit _____

PET HEALTH HISTORY

Name of pet _____ Dog Cat

Breed _____ Color _____ Birthdate _____

Male Neutered Female Spayed

Vaccination History (Date and type of last vaccines) _____

Name of last veterinary clinic _____

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Behavior 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"/> Gagging | <input type="checkbox"/> Shaking Head | _____ |

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. I understand that I will be charged a \$30.00 returned check fee in the case of a bounced check.

Signature of Owner _____ Date _____