Welcome

Thank you for giving us the opportunity to care for your pet. We'll 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. Thank You!

REGISTRATION

TODAY'S DATE_____

OWNER'S NAME_____ SPOUSE/OTHER_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

DRIVER'S LICENSE_____ HOW DID YOU HEAR ABOUT OUR CLINIC_____

EMPLOYER'S NAME & ADDRESS_____

SPOUSE'S/OTHER'S EMPLOYER NAME & ADDRESS_____

AT WHAT TIME_____ AND AT WHAT NUMBER_____ IS IT BEST TO CALL ABOUT YOUR PET

IN CASE OF **EMERGENCY**, PLEASE CALL_____

PLEASE DESCRIBE OTHER ANIMALS IN HOUSEHOLD_____

REASON FOR VISIT_____

PET HEALTH HISTORY

PET'S NAME_____ DATE OF BIRTH/AGE_____

TYPE OF ANIMAL ☐ DOG ☐ CAT ☐ OTHER_____

SEX: ☐ MALE ☐ NEUTERED ☐ FEMALE ☐ SPAYED

BREED_____ COLOR_____ WEIGHT_____

VACCINATION HISTORY (Date and type of last vaccinations)_____

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

- ☐ Behavior Problems
- ☐ Bleeding Gums
- ☐ Breathing Problems
- ☐ Coughing
- ☐ Diarrhea
- ☐ Eye bulging or bloodshot
- ☐ Gagging
- ☐ Lack of Appetite
- ☐ Limping
- ☐ Loss of Balance
- ☐ Scooting
- ☐ Scratching
- ☐ Seems Depressed
- ☐ Shaking Head
- ☐ Sneezing
- ☐ Increased Thirst and/or Urination
- ☐ Vomiting
- ☐ Weakness
- ☐ Weight Problem
- ☐ Other_____

CURRENT MEDICATIONS_____

DESCRIBE YOUR PET'S DIET (Brand & Amount)_____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. **I assume the responsibility for all charges incurred** in the care of this animal. I also understand that these charges will be **paid at time of service** and that a deposit may be required for hospitalization or surgical treatment. **I also understand that appointment cancellations require a 24-hour notice. Cancellations made with less than 24 hours are subject to a $20.00 fee, with payment required before rescheduling.**

SIGNATURE OF OWNER_____ DATE_____

South Mountain Veterinary Hospital

Authorization for Release of Patient Information

Patient name: _____ Owner Name: _____

I hereby authorize: South Mountain Veterinary Hospital
266 Church Rd.
Mountain Top, PA 18707
(570) 474-5355

to disclose the above named animals' medical records to be used by other veterinary practices, groomers, animal shelters or boarding kennels for:

Continuing care, Second Opinion, Consultation and/or insurance purposes

I understand:

- That this authorization in voluntary and I may refuse to sign this authorization
- I may inspect or copy the information used or disclosed
- South Mountain Veterinary Hospital may charge a fee for this service
- This authorization has no expiration date
- I may revoke this authorization at any time by notifying South Mountain Veterinary hospital with a signed and dated written revocation
- Written revocation will not affect any actions taken prior to receipt of said written revocation

Signature of owner _____
Date_____

Print Owners Name _____Chart #_____