



NEW PRAGUE VETERINARY CLINIC  
NEW PATIENT REGISTRATION FORM

OWNER INFORMATION

Owner name:		Email:	
Street address:		Primary phone no:	Alternate phone no:
City:		State:	ZIP Code:
Spouse/Co-owner name:			Spouse/co-owner phone no:
How did you hear about us?: <input type="checkbox"/> Recommended by _____			
<input type="checkbox"/> Internet <input type="checkbox"/> Sign/Drive-by <input type="checkbox"/> Newspaper/Local Ad <input type="checkbox"/> Other _____			
Number of Pets: Dogs _____ Cats _____			
Reason for Visit:			

PET INFORMATION

Name of Pet(s):		<input type="checkbox"/> Dog	<input type="checkbox"/> Cat
Breed:	Color:	Birthdate (or approximate age):	
<input type="checkbox"/> Male	<input type="checkbox"/> Neutered	<input type="checkbox"/> Female	<input type="checkbox"/> Spayed
Vaccination History (Date and type of last vaccinations):			
Pet's Current Medications:			
Describe your pet's diet (type/brand/amount):			
Please check any symptoms or problems you have noticed about your pet:			
<input type="checkbox"/> Behavioral Problems	<input type="checkbox"/> Gagging	<input type="checkbox"/> Shaking Head	
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Lack of Appetite	<input type="checkbox"/> Sneezing	
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Limping	<input type="checkbox"/> Thirst/Urination Increased	
<input type="checkbox"/> Coughing	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Scooting	<input type="checkbox"/> Weakness	
<input type="checkbox"/> Eye Bulging or Bloodshot	<input type="checkbox"/> Scratching/Itching	<input type="checkbox"/> Other _____	

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 are required to be paid at the completion of the visit.

\_\_\_\_\_  
Owner Signature

\_\_\_\_\_  
Date

