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?: ❑ Recommended by _____

❑ Internet ❑ Sign/Drive-by ❑ Newspaper/Local Ad ❑ Other _____

Number of Pets: Dogs _____ Cats _____

Reason for Visit:

PET INFORMATION

Name of Pet(s):		❑ Dog ❑ Cat
Breed:	Color:	Birthdate (or approximate age):

❑ Male ❑ Neutered ❑ Female ❑ 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:

❑ Behavioral Problems	❑ Gagging	❑ Shaking Head
❑ Bleeding Gums	❑ Lack of Appetite	❑ Sneezing
❑ Breathing Problems	❑ Limping	❑ Thirst/Urination Increased
❑ Coughing	❑ Loss of Balance	❑ Vomiting
❑ Diarrhea	❑ Scooting	❑ Weakness
❑ Eye Bulging or Bloodshot	❑ Scratching/Itching	❑ 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*