Animal Medical Clinic

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

REGISTRATION

Owner _____ **Co-Owner** _____

Address _____ ❒ Spouse ❒ Significant Other ❒ Relative ❒ Friend

City _____ Zip _____ Co-Owner Phone: _____

Occupation: _____ Occupation _____

Employer: _____ Employer _____

Home Phone _____ Cell Phone _____ Work Phone _____

Which phone is the primary contact number? ❒ Home ❒ Cell ❒ Work ❒ Co-Owner's Number

May we contact you by text messaging? ☐ Yes ☐ No If so, which number: _____

May we contact you by email? ☐ Yes ☐ No If yes, email address _____

Children (Names) _____

How did you find us? ❒ Yellow Pages ❒ Sign ❒ Internet ❒ Google ❒ AMC Website ❒ other _____

❒ Referred by someone, whom can we thank? Name: _____

PET INFORMATION

Pet's Name: _____ Species: ❒ Canine ❒ Feline ❒ other _____

Breed: _____ Color/Markings: _____ Birthday/Age: _____

Sex: ❒ Male ❒ Female ❒ Neutered/Spayed Does your pet have a microchip? ❒ Yes ❒ No

Diet brand: _____ amount you feed _____ how often _____

Does your pet board or go to day care? ❒ Yes ❒ No if yes, where _____

Is your cat: ❒ Strictly Indoors ❒ Supervised Outdoors ❒ Unattended Outdoors ❒ Indoor/Outdoor

List names, species, sex, and age of other pets: _____

Previous Veterinarian: _____ Do you have pet insurance? ❒ Yes ❒ No

What is the reason for this visit? _____

Is your pet currently experiencing or recently experienced any abnormal:

❒ Behavior	❒ Eye discharge	❒ Scooting	❒ Thirst	❒ Defecation
❒ Bleeding	❒ Urination	❒ Scratching	❒ Gagging	❒ Loss of balance
❒ Breathing	❒ Eating Patterns	❒ Depression	❒ Vomiting	❒ Sneezing
❒ Coughing	❒ Limping	❒ Head shaking	❒ Weakness	❒ Odor

AUTHORIZATION

All accounts are to be paid in full at the time of service.

_____ Signature of Responsible Party

_____ Date