



Welcome

Thank you for giving North Spokane Veterinary Clinic the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank you!

REGISTRATION

Owner _____ SS # _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Driver's License No. _____ Email Address _____
 Employer Name & Address _____
 Spouse or Co-owner's Name _____ SS # _____
 Home Phone _____ Work Phone _____ Spouse Work Phone _____
 Emergency Contact Name _____ Phone _____
 Number of pets: Dogs _____ Cats _____ Other (specify) _____
 How did you learn of our clinic? Yellow Pages Recommendation Sign Other _____
 If recommended, by whom? _____ Senior Discount if 60 or older. Please check box if applicable
 How would you prefer reminders? via Mail Email

PET HEALTH HISTORY

Name of pet _____ Dog Cat Other _____
 Breed _____ Color _____ Birthdate _____
 Sex Male: Neutered Not Neutered Female: Spayed Not Spayed
 Vaccination History (Date and type of last vaccinations) _____
 Reason for Visit today _____
 Previous Veterinarian(s) where past records can be obtained if necessary _____
 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 _____
 Has your pet been treated for any illness in the past year? _____
 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.

Signature of Owner _____ Date _____
 Method of payment Cash Check MasterCard VISA Veterinary Care Credit* _____

*Ask for information and application if interested and not currently enrolled.