NORWICH REGIONAL ANIMAL HOSPITAL

Treating Best Friends

Pet Owner's Name _____

Pet's Name_____Cat ☐ Dog ☐ Other (Specify) _____

_____ Male ☐ / Female ☐ Is your pet spayed or neutered? Yes ☐ / No ☐

Birth Date (or estimated age) _____

Breed _____ Color _____ Microchip Number _____

My Pet Came From: Friend ◯ / Breeder ◯ / Pet Shop ◯ / Humane Society ◯ / Rescue ◯

Describe Your Pet's Diet: _____

Current Medication/Supplements:_____

Does Your Pet Live: Indoors ◯ / Outdoors ◯ / Both ◯

Please List Known Medical Problems/Concerns: _____

Please Check Any Symptoms or Problems You've Noticed With Your Pet:

◯ Appetite Loss ◯ Gagging ◯ Sneezing ◯ Thirst ◯ Behavioral Changes ◯ Bleeding Gums

◯ Limping ◯ Vomiting ◯ Coughing ◯ Breathing Problems ◯ Loss of Balance ◯ Depression

◯ Scooting ◯ Diarrhea ◯ Increased Urination ◯ Weakness ◯ Scratching ◯ Shaking Head ◯ Eye Disorders

◯ Other: _____

Did you bring your vaccination history with you? Yes ◯ / No ◯

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 the animal. I also understand that all professional fees are due at the time services are rendered.

Signature of Client _____ Date_____