

PET REGISTRATION AND HISTORY

MICHAEL K. JOHNS, D.V.M.

CLARE A. SHANNON, D.V.M.

Leah Scott, D.V.M.

4850 Cove Creek Dr.

Brownsboro, AL 35741

Telephone: (256) 534-7387

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

Date_____

REGISTRATION

Owner_____ Email_____

Address_____ Zip Code_____

Cell Phone_____ Home Phone_____ Work Phone_____

Spouse_____ Spouse Work Phone_____ Spouse Cell Phone _____

Emergency Contact Name_____ Phone_____

How did you learn of our clinic?

If recommended, by whom? _____

☐ Phone Book

☐ Sign

☐ Recommendation

☐ Website

☐ Facebook

☐ Other_____

Number of pets: Dogs_____

Cats _____

Reason for visit_____

PET HEALTH HISTORY

Name of pet_____ ☐ Dog ☐ Cat

Breed_____ Color_____ Birthdate_____

☐ Male

☐ Neutered

☐ Female

☐ Spayed

Vaccination History (Date and type of last vaccines)_____

Name of last veterinary clinic_____

Please check any symptoms or problems that you have noticed about your pet:

☐ Behavior Problems

☐ Lack of Appetite

☐ Sneezing

☐ Bleeding Gums

☐ Limping

☐ Thirst and/or Urination Increased

☐ Breathing Problems

☐ Loss of Balance

☐ Vomiting

☐ Coughing

☐ Scooting

☐ Weakness

☐ Diarrhea

☐ Scratching

☐ Other_____

☐ Eye Bulging or Bloodshot

☐ Seems Depressed

☐ Gagging

☐ Shaking Head

Pet's current medications_____

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. I understand that I will be charged a \$30.00 returned check fee in the case of a bounced check.

Signature of Owner_____ Date_____