WELCOME

Pet Parent(s) Information

Name (Last, First) _____ ☐Co-owner _____
Street Address _____ P.O. Box_____
City _____ State _____ Zip _____County _____
Home Phone _____Cell Phone _____Work _____
Email_____
Spouse/Co-owner Home Phone _____ Cell Phone _____Work _____
Email _____
Emergency Contact: _____ Phone_____
How did you hear about our practice? _____
Number of pets _____

Pet Information

Pet Name: _____ Age/D.O.B _____ ☐Male ☐Female ☐Unknown
Breed _____Color _____
Obtained From: ☐Breeder ☐Pet shop ☐Humane Society ☐Other_____
Previous Vet ☐Yes ☐No Name _____ Phone _____
Diet_____
Medication(s) ☐Yes ☐No If yes, list Meds:_____
☐Prior surgery_____ ☐Prior illness_____ ☐Other_____

Pet Name: _____Age/D.O.B _____ ☐Male ☐Female ☐Unknown
Breed _____Color _____
Obtained From: ☐Breeder ☐Pet shop ☐Humane Society ☐Other_____
Previous Vet ☐Yes ☐No Name _____ Phone _____
Diet_____ Medication(s) ☐Yes ☐No If yes, list Meds:_____
☐Prior surgery_____ ☐Prior illness_____ ☐Other_____

Please check any symptoms or problems you've noticed with your pet(s)

☐Appetite loss	☐Gagging	☐Sweating	☐Eye Problems
☐Behavioral changes	☐Coughing	☐Thirsty	☐Breathing problems
☐Limping	☐Vomiting	☐Diarrhea	☐Sneezing
☐Weakness	☐Depression	☐Scooting	☐Gums bleeding
☐Scratching	☐Loss of balance	☐Urination increase	☐Shaking head

☐Other_____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume all responsibility for all charges in the care of my pet. I understand ***ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.***

Signature of client responsible for pet(s):_____Date : _____

Thank you for letting **Windward Animal Hospital** be your pet's health-care team!!!