



Welcome to Foothills Veterinary Hospital

Registration

Date _____

Owner _____ Driver License # _____

Address _____ City _____ State _____ Zip _____

E-mail Address _____

Occupation _____ Employer _____

Spouse/Additional Owner _____ Driver License # _____

Occupation _____ Employer _____

Home/Cell Phone _____ Work Phone _____ Spouse Phone _____

Emergency Contact _____ Phone _____

How did you learn of our clinic? _____

Number of Pets: Dogs _____ Cats _____ Other (specify) _____

Pet Health History

Pet's Name _____ () Dog () Cat () Other (Specify) _____

Breed _____ Color _____ Birthdate _____

() Male () Neutered () Female () Spayed

Vaccination History (date, type, and where given) _____

- | | | |
|-------------------------------------|-----------------------|------------------|
| () Behavior Problems | () Breathing Problem | () Diarrhea |
| () Lack of Appetite | () Loss of Balance | () Scratching |
| () Sneezing | () Vomiting | () Gagging |
| () Bleeding Gums | () Coughing | () Shaking Head |
| () Limping | () Scooting | () Other |
| () Increased Drinking or Urinating | () Weakness | |

Authorization

I, being responsible for the above mentioned animal, have the authority to grant you my consent to receive, prescribe for, treat, and/or operate upon my 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 also understand that if my account needs to go to collection, I am responsible for any fees associated with this process including all collection and attorney fees.***

Signature of Owner _____ Date _____

Method Payment: () Cash () Check () Visa () Mastercard () Other

Additional Pets

_____ () Dog () Cat () Other (Specify) _____

Breed _____ Color _____ Birthdate _____

() Male () Neutered () Female () Spayed

Vaccination History (date, type, and where given) _____

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