

Pet Registration & History

Hartland Animal Hospital

6425 South Jackson Hwy.
Horse Cave, KY 42749

Telephone: 270-786-5545

Welcome to our Practice! Thank you for giving us 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! Date _____

REGISTRATION

Owner: _____ **DL#** _____ **Date of Birth** _____
 Address _____
 City _____ State _____ Zip _____
 Spouse _____ DL# _____ Date of Birth _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Emergency Contact Name _____
E-Mail Address _____
 How did you learn of our practice? (Check all that apply)
 Yellow Pages Clinic Sign Other (please specify) _____
 Newspaper Personal recommendation (by whom?) _____

PET HEALTH HISTORY

Name of Pet _____ Dog Cat Other _____
 Breed _____ Color _____ Birth date: ____/____/____
 Male Neutered / Female Spayed

Reason For Visit: _____
 Vaccination History (Date and type of last vaccinations)

	Date Completed		Date Completed
Rabies	____/____/____	Kennel Cough	____/____/____
Parvo/Distemper	____/____/____	Lyme's Disease	____/____/____
Feline Leukemia	____/____/____	Heartworm Test	____/____/____
FVRCP	____/____/____	Fecal Exam	____/____/____

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

<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"/> Drug Reaction _____
<input type="checkbox"/> Eye Bulging or Bloodshot	<input type="checkbox"/> Seems Depressed	<input type="checkbox"/> Other _____
<input type="checkbox"/> Gagging	<input type="checkbox"/> Shaking Head	_____

Pet's current medications _____
 Describe your pet's diet _____

AUTHORIZATION

I authorize Hartland Animal Hospital to examine, perform necessary treatments, and/or prescribe medications for my pet today. I realize that all charges incurred at this time and all visits are my sole responsibility, and that ***all fees are due at the time services are rendered***. I also understand that ***credit will not be given*** for any services preformed. If surgery or hospitalization is necessary, I realize that a deposit may be required before I leave today for the prescribed treatment/procedure.

Signature	Date	Please indicate your choice of payment for services and/or medications rendered: <input type="checkbox"/> CASH/CHECK <input type="checkbox"/> CREDIT CARD
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