Welcome

Edmond East Animal Hospital

We know your pet's health is important and we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form completely.

Thank You!

Registration

Client Name: _____ **Date:** _____

Address: _____

_____ **Email:** _____

Secondary Name (on client record): _____

Primary Phone: _____ **Type:** _____

Phone: _____ **Type:** _____

How did you learn about our clinic? ☐ Facebook ☐ Sign Outside ☐ Drive By ☐ Recommendation ☐ Website ☐ Newspaper ☐ Other: _____

If recommended, by whom? _____

Pet Health History

Name of Pet: _____ ☐ Dog ☐ Cat ☐ Other: _____

Breed: _____ **Color:** _____ **Birthdate/ Age:** _____

☐ Male ☐ Neutered ☐ Female ☐ Spayed ☐ Unknown

Medical History is from: **Clinic Name:** _____ **Phone Number:** _____

Vaccination History (date and type of last vaccinations): _____

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

- ☐ Arthritis
- ☐ Bad Breath/Dental Concerns
- ☐ Behavioral Problems
- ☐ Breathing Problems
- ☐ Change in Thirst or Appetite
- ☐ Coughing
- ☐ Diarrhea
- ☐ Difficulty Walking/Standing
- ☐ Eye or Ear Concerns
- ☐ Lethargy/Depression
- ☐ Limping
- ☐ Scooting
- ☐ Scratching
- ☐ Shaking Head
- ☐ Sneezing
- ☐ Vomiting
- ☐ Urination Problems
- ☐ Other: _____

Pet's current medications, including Heartworm and Flea/Tick Preventatives: _____

Describe your pet's diet: _____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for 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.

Signature of Owner: _____ **Date:** _____

Method of Payment: ☐ Cash ☐ Check ☐ Mastercard ☐ Visa ☐ Care Credit