



**Welcome
Registration Form**

Melinda Cumming, DVM

Margaret Hammond, DVM

Deborah Wolf, DVM

Owner _____ Date _____
 Address _____ City _____ Zip _____
 Home # _____ Work# _____ Cell# _____
 Spouse/Partner _____ Work # _____
 Email Address _____
 Emergency Contact Name _____ Phone# _____

How did you learn of our clinic:

Yellow Pages _____ Sign _____ Recommendation _____ Other _____
 Names of Previous Vet(s) _____
 If recommended, by whom _____

Number of pets: Dogs _____ Cats _____ Other _____
 Breed _____ Color _____ Birth Date _____
 Male _____ Neutered _____ Female _____ Spayed _____
 Vaccination History (Date and type of last vaccines)

Please Circle any/all symptoms OR problems that you have noticed:

Behavior Problems	Lack of Appetite	Sneezing
Bleeding Gums	Limping	Thirst
Breathing Problems	Loss of Balance	Urination
Coughing	Scotting	Vomiting
Diarrhea	Scratching	Weakness
Eye(s) Bulging or Bloodshot	Seems Depressed	Other

Pets current prescription medication and/or supplements

Authorization

I hereby authorize the veterinarian to examine, prescribe, for or treat the above described pet. I assume 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/guardian _____ Date _____