

# WELCOME TO COBB ANIMAL CLINIC

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you may have concerning your pet's health. To insure the best possible care, please take the time to fill in this form completely. Thank you!

## REGISTRATION

Today's Date \_\_\_\_\_

Owner's Name \_\_\_\_\_ Spouse/Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Driver's License # \_\_\_\_\_

Employer's Name & Address \_\_\_\_\_

At What Time \_\_\_\_\_ & At What Phone # \_\_\_\_\_ Is Best to Call About Your Pet?

In Case of EMERGENCY, Please Call \_\_\_\_\_

Reason For Visit \_\_\_\_\_

How did you learn of our practice?  Yellow Pages  Location  Internet

Referral-Name of Referring Individual: \_\_\_\_\_

## PET HEALTH HISTORY

Pet's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Type of Animal:  Dog  Cat

Sex:  Male  Neutered  Female  Spayed

Breed \_\_\_\_\_ Color \_\_\_\_\_ Weight \_\_\_\_\_

Previous Veterinarian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Vaccination History (Date and Type of Last Vaccinations):  
\_\_\_\_\_

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bad Breath         | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Thirst          |
| <input type="checkbox"/> Behavior Problems  | <input type="checkbox"/> Limping          | <input type="checkbox"/> Vomiting        |
| <input type="checkbox"/> Bleeding Gums      | <input type="checkbox"/> Loss of Balance  | <input type="checkbox"/> Weakness        |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Scooting         | <input type="checkbox"/> Weight Problems |
| <input type="checkbox"/> Coughing           | <input type="checkbox"/> Scratching       | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Seems Depressed  |  |
| <input type="checkbox"/> Eye Bulging        | <input type="checkbox"/> Shaking Head     |  |
| <input type="checkbox"/> Gagging            | <input type="checkbox"/> Sneezing         |  |

Current Medications \_\_\_\_\_

Describe Your Pet's Diet \_\_\_\_\_

## AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I understand that these charges must be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner/Agent \_\_\_\_\_ Date \_\_\_\_\_

Method of Payment  Cash  Check  Credit Card  CareCard

