



3520 Marion Ave.
Finleyville, PA 15332
724-348-0405

*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

Owner: _____ Date: _____

Address: _____ Email: _____

Significant Other: _____ Drivers License: _____

Phone: _____ Work Phone: _____ Spouse Phone: _____

Emergency Contact Name: _____ Phone: _____

How did you learn about our clinic? Sign Outside Yellow Pages Facebook Recommendation
 Website Newspaper Other: _____

If recommended, by whom? _____

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

Reason for Visit: _____

PET HEALTH HISTORY

1. Name of Pet: _____ Dog Cat Other : _____

Breed: _____ Color: _____ Birthdate: _____

Undetermined Male Neutered Female Spayed

2. Name of Pet: _____ Dog Cat Other : _____

Breed: _____ Color: _____ Birthdate: _____

Undetermined Male Neutered Female Spayed

Did you bring your Vaccination History? Yes No

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Dental Issues |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Limping | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Thirst and Urination Increased |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Scooting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Weakness |
| <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 | |

Pets current medications: _____

Describe your pet's diet: _____

We expect Payment In Full at the time of service. We accept Cash, Check, Visa, MasterCard, American Express, Discover, and Care Credit. Thank You!

Client Signature: _____ Date: _____