

Welcome to Richmond Veterinary 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 this form out completely. Thank you!

REGISTRATION

Owner: _____ Date: _____
Address: _____ SSN: _____
Significant Other: _____ E-Mail: _____
Phone: _____ Cell Phone: _____ Other Phone: _____
Emergency Contact Name: _____ Phone _____
How did you learn about our clinic? Sign Outside Yellow Pages Facebook Recommendation
 Website News Paper Other: _____
If recommended, by whom? _____
Number of Pets Dogs: _____ Cats: _____ Other (Specify): _____
Reason for Visit: _____

PET HEALTH HISTORY

Name of Pet: _____ Dog Cat Other: _____
Breed: _____ Color: _____ Birthdate: _____
 Undetermined Male Neutered Female Spayed
Vaccination History (date and type of last vaccinations): _____

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

Pet's current medications: _____
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. I understand that all outstanding balances are subject to ongoing finance and billing fees/charges until balance is paid in full.

Signature of Owner: _____ Date: _____
Method of Payment: Cash Check Mastercard Visa Other: _____

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