Belpar
Pet Care
Centre
...because your pet leaves pawprints on our hearts too

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

REGISTRATION

TODAY'S DATE:__________________

OWNER'S NAME:____SPOUSE/OTHER NAME:________________________________

ADDRESS:____CITY:______________________STATE:_________ZIP:____________

HOME PHONE: _______________________WORK PHONE:______________________CELL PHONE:__________________________

E-MAIL ADDRESS:____

SSN/SIN#____DRIVERS LICENSE #____

EMPLOYER'S NAME AND ADDRESS____

WHEN IS IT BEST TO CALL YOU ABOUT YOUR PET? AT WHAT TIME?______________WHICH PHONE NUMER?_______________

IN CASE OF AN EMERGENCY, PLEASE CALL:____

PLEASE DESCRIBE OTHER ANIMAL(S) IN HOUSEHOLD:____

REASON FOR VISIT:____

PET HEALTH HISTORY

PET'S NAME:____DATE OF BIRTH:_______________________________

TYPE OF ANIMAL:____________________________BREED:___________________________COLOR:_________________________

SEX:___________________________SPAYED/NEUTERED?____

VACCINATION HISTORY: (Date and Type of Vaccinations, or attach copy from previous care)

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____

PLEASE CHECK ANY SYMPTOMS OR PROBLEMS THAT YOU HAVE NOTICED ABOUT YOUR PET:

____Bad Breath
____Behavior Problems
____Bleeding Gums
____Breathing Problems
____Coughing
____Diarrhea
____Eye Bulging or Bloodshot
____Gagging
____Lack of Appetite
____Limping
____Loss of Balance
____Scooting
____Sratching
____Seems Depressed
____Shaking Head
____Sneezing
____Thirst and/or Urination Increased
____Vomiting
____Weakness
____Weight Problem
____OTHER:________________
____

CURRENT MEDICATIONS:____

DESCRIBE YOUR PET'S DIET:__________________________________TREATS(TYPE/HOW OFTEN):________________________

AUTHORIZATION

I hearby authorize the veterinarian to examine, prescribe, or treat the above described pet. I assume responsibility for all charges incurred in the care of my pet. I understand that these charges must be paid at the time of release and that a deposit may be required for surgical treatment. Finally, I acknowledge that any returned checks will result in a $25.00 fee.

SIGNATURE OF OWNER/AGENT:____DATE:________________________________

METHOD OF PAYMENT: CASH CHECK MASTERCARD/VISA/DISCOVER CARE CREDIT

MARKETING FEEDBACK

Please tell us how you heard about our practice: WEBSITE ONLINE OTHER:________________________________

REFERRED BY:____