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 the time to fill in this form completely. Thank You!

REGISTRATION

OWNER:_____ SPOUSE'S NAME:_____
MAILING ADDRESS:_____
CITY:_____ ST:_____ ZIP:_____
PRIMARY PHONE # _____ SECONDARY PHONE # _____
EMAIL ADDRESS:_____

How did you learn about our clinic?
____Online Search ___Clinic Sign ___Yellow Pages ___Recommendation ___Other

PATIENT INFORMATION

	PET # 1	PET # 2	PET # 3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX			
SPAYED OR NEUTERED			
Does your pet have a microchip?	___Yes ___No	___Yes ___ No	___Yes ___No

Reason for visit?_____
Did you bring a copy of your pet's previous vaccination record?_____
If not, where did he/she last get vaccinated?_____clinic#_____
Any previous serious illness or surgeries?_____
Any allergies to vaccinations or medications?_____
List your pet's currrent medication?_____

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 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:_____DATE:_____

Circle Method of Payment: Cash Check Mastercard Visa Discover Debit American Express
ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

Citrus Animal Clinic **270 US 27 South** **Lake Placid, FL 33852** **863-465-2176**