WELCOME TO CROSSROADS VETERINARY CLINIC

412-416 Lexington Road, Versailles, KY 40383

859-873-6463 Fax 1-866-484-5969

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you may have about your pet's health. To ensure the best care possible, please fill out this form completely.

OWNER ______________________________ SPOUSE ______________________________

ADDRESS ____________________APT/UNIT ____ CITY________________ STATE_____ ZIP ______

PHONE ____/_____-______ SPOUSE PHONE ____/_____-______ EMAIL ______________________

How did you learn of our clinic? __ Recommendation __ Sign __ Internet __ Other ________________

If recommended, by whom? ____

REASON FOR VISIT ____

PET HEALTH HISTORY

Number of Pets ____ Dogs ____Cats Other (specify) ______________________

PET NAME ________________________ DOG ___ CAT ___ OTHER ________________

BREED ____________________ COLOR __________________ DATE OF BIRTH __________

MALE ____ NEUTERED ____ FEMALE ____ SPAYED ____

VACCINATION HISTORY (DATES AND TYPE) ______________________________________

____

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

__ Behavior Problems
__ Bleeding Gums
__ Breathing Problems
__ Coughing
__ Diarrhea
__ Eye Bulging
__ Gagging
__ Lack of Appetite
__ Limping
__ Loss of Balance
__ Scooting
__ Scratching
__ Seems Depressed
__ Shaking Head
__ Sneezing
__ Increased Thirst/Urination
__Vomiting
__Weakness
__Other ____________________

PETS CURRENT MEDICATIONS ______________________________________

PETS CURRENT DIET (BRAND, WET OR DRY) ______________________________

AUTHORIZATION

I authorize Dr Ashley Keith or Dr Haley Hancock to examine, prescribe for, or treat the above-described pet(s). 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 ___/___/____

Method of payment __Cash __ Check __ Mastercard __ Visa __ Discover __ American Express __ Care Credit __

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412-416 LEXINGTON ROAD
VERSAILLES, KENTUCKY 40383
859-873-6463
Fax 1-866-484-5969
crossroadsvets@yahoo.com

AUTHORIZATION TO RELEASE OR REQUEST VETERINARY RECORDS

❖ ***PET OWNER INFORMATION:***

NAME: ____

EMAIL ADDRESS: ___________________________________

❖ ***PET INFORMATION***:

NAME: ________________________ BREED: ___________________

NAME: ________________________ BREED: ___________________

NAME: ________________________ BREED: ___________________

NAME: ________________________ BREED: ___________________

I hereby certify that I am the owner or authorized agent of the owner of the above-described pet(s). **I hereby authorize Crossroads Veterinary Clinic to release and or request medical information about my pet(s) to or from other veterinarians, boarding or grooming facilities, hospitals, health departments, law enforcement or animal control.**

______________________________________ ___________________________
Owner or Owner's Agent Signature Date