WELCOME

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 insure the best care possible, please take the time to fill out this form completely. Thank you!

REGISTRATION

Owner ______________________________ Spouse ______________________________
Address ______________________________ City ____________________ State _______ Zip _________
Home # ____________________ Cell # ____________________ Spouse Cell # ________________
EMAIL ______________________________
Emergency Contact Name ________________________ Phone Number ______________________

How did you learn of our clinic? ____ Yellow Pages ____ Recommendation ____ Sign ____ Other ______________
If recommended, by whom? ____

Number of pets: Dogs ______ Cats ______ Other (specify) ______________________________

Reason for Visit ____

PET HEALTH HISTORY

Pet Name ____________________ Dog ____ Cat ____ Other ______________________

Breed ____________________ Color ____________________ Date of Birth ______________

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:

____ Behavior Problems
____ Bleeding Gums
____ Breathing Problems
____ Coughing
____ Diarrhea
____ Eye Bulging/Bloodshot
____ Gagging
____ Lack of Appetite
____ Limping
____ Loss of Balance
____ Scooting
____ Scratching
____ Seems Depressed
____ Shaking Head
____ Sneezing
____ Increased Thirst/Urination
____ Vomiting
____ Weakness
____ Other ________________

Pets current medications ____

Describe your Pets diet ____

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 ____________________

Method of payment ____ Cash ____ Check ____ MasterCard ____ Visa ____ Discover ____ American Express

*** PLEASE COMPLETE RECORDS RELEASE FORM ON THE BACK OF THIS FORM***

CROSSROADS VETERINARY CLINIC
412 LEXINGTON ROAD
VERSAILLES, KENTUCKY
40383
859-873-6463
Fax 1-866-484-5969

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, and release medical information to boarding or grooming facilities, hospital or health department, and law enforcement or animal control.** Crossroads Veterinary Clinic policy is to provide the requested medical information within two (2) business days of the request. Copy costs are twenty-five cents per page plus postage.

______________________________ ____________________
Owner or Owner's Agent Signature Date