



## Patient Registration And History



Holden Animal Clinic & Supply, Inc.  
709 W 2nd  
Holden MO 64040  
(816) 732-4412

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you might have about your pet's health. To insure the best care possible, please take a few minutes to fill out this form so we have an accurate record and an understanding of your pet's previous medical history and current condition. Thank you!

Date \_\_\_\_\_

### REGISTRATION

Please check one:  New Client  Current Client-New Pet

Owner's Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Driver Lic. No. \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Employer \_\_\_\_\_ Spouse or Co-Owner's Name \_\_\_\_\_

How did you learn of our clinic?  Sign  Yellow Pages  Web Site  Recommendation  Other \_\_\_\_\_

If recommended, whom may we thank? \_\_\_\_\_

Cell Phone or alternate contact method \_\_\_\_\_

### PET HEALTH HISTORY

Name of pet \_\_\_\_\_  Dog  Cat  Other \_\_\_\_\_

Breed \_\_\_\_\_ Color \_\_\_\_\_ Birthdate or approximate age \_\_\_\_\_

Male  Neutered  Female  Spayed

Date of last vaccinations \_\_\_\_\_ Date of last deworming or fecal test \_\_\_\_\_

Is pet currently taking a Heartworm preventative? \_\_\_\_\_ What kind? \_\_\_\_\_

Is pet currently on any medications? \_\_\_\_\_ If so, what are they? \_\_\_\_\_

Previous clinic where past records could be obtained if necessary \_\_\_\_\_

Any long term health problems? \_\_\_\_\_

Describe your pet's diet \_\_\_\_\_

Please check any symptoms or problems that you have noticed about your pet.

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Lack of Appetite                  | <input type="checkbox"/> Sneezing                 | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Limping           | <input type="checkbox"/> Increased Thirst and/or Urination | <input type="checkbox"/> Breathing Problems       | <input type="checkbox"/> Weakness      |
| <input type="checkbox"/> Vomiting          | <input type="checkbox"/> Coughing                          | <input type="checkbox"/> Scooting                 | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Scratching                        | <input type="checkbox"/> Eye Bulging or Bloodshot |  |
| <input type="checkbox"/> Shaking Head      | <input type="checkbox"/> Gagging                           | <input type="checkbox"/> Depressed                |  |

### AUTHORIZATION

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.

Signature of owner or responsible party \_\_\_\_\_ Date \_\_\_\_\_

Method of payment:  Cash  Check  Credit Card Other  \_\_\_\_\_