



# New Family Member

Thank you for giving us the opportunity to care for your pet.  
We'll 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!



## Pet Health History

Name of Pet: \_\_\_\_\_ Type of Pet: \_\_\_\_\_ Breed: \_\_\_\_\_

Color: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Vaccination History: (Date and Type of last vaccinations) \_\_\_\_\_  
\_\_\_\_\_

Pet's current medications: \_\_\_\_\_

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

Describe your pet's lifestyle: \_\_\_\_\_

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

Behavioral problems  
Limping  
Coughing  
Scratching  
Seems depressed

Lack of appetite  
Breathing problems  
Scooting  
Eye bulging or bloodshot  
Thirst and/or urination increased

Sneezing  
Loss of balance  
Weakness  
Gagging

Bleeding gums  
Vomiting  
Diarrhea  
Shaking head

Other \_\_\_\_\_  
\_\_\_\_\_

## AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and/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 and/ or medical treatment. I agree by signature below failure to pay at time of service will cause late charges of 18% of balance to be assessed if not paid in full within 30 days. Balances that go over 30 days are subject to legal and collection proceedings. Necessary costs such as court fees, legal fees or any other fees incurred by D.C.A.H. in the collection of this account will be client's responsibility in full.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Method of Payment (please circle one):    Cash    Check    Master card/Visa    Other \_\_\_\_\_