STATESBORO BULLOCH REGIONAL VETERINARY HOSPITAL, PC

We know your pet's health is important and we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form completely. Thank you!

REGISTRATION

Owner _____ SS# _____
Address (residential) _____
Address (mailing) _____
Home Phone _____ Cellular Phone _____ Work Phone _____
E-mail address (confidential) _____
Place of Work _____
Spouse/Other _____ SS# _____
Place of Work _____
Emergency Contact Name _____ Phone _____
How did you learn about our clinic? ☐ Yellow Pages ☐ Recommendation
☐ Sign ☐ Other _____
If recommended, by whom? _____
Number of pets: Dogs _____ Cats _____ Other (specify) _____
Reason for visit _____
_____

PET HEALTH HISTORY

Name of pet _____ ☐ Dog ☐ Cat ☐ Other _____
Breed _____ Color _____ Birthdate/Age _____
☐ Male ☐ Neutered ☐ Female ☐ Spayed
Vaccination History (Date and type of last vaccinations if not at this clinic) _____
_____
Please check any symptoms for problems that you have noticed about your pet.

☐ Behavioral Problems	☐ Lack of Appetite	☐ Sneezing
☐ Breathing Problems	☐ Limping	☐ Thirst and/or Urination Increased
☐ Coughing	☐ Loss of Balance	☐ Vomiting
☐ Diarrhea	☐ Scooting	☐ Weakness
☐ Eye Bulging or Bloodshot	☐ Scratching	☐ Other _____
☐ Gagging	☐ Shaking Head	

Pet's current medications _____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and/or treat my pet(s). I assume full responsibility for all charges incurred for the care of this animal. I also understand that theses charges will be paid that the time of release and that a deposit may be required for surgical treatment and hospitalization. I also understand and agree to a $3.50 monthly billing charge and responsibility for any collection charges for a balance due for any reason.
Signature of Owner _____ Date _____
Method of Payment ☐ AMEX ☐ CareCredit ☐ Cash ☐ Discover ☐ MasterCard ☐ Visa