



NORWICH REGIONAL ANIMAL HOSPITAL

Treating Best Friends

Pet Owner's Name _____

Pet's Name _____ Cat / Dog / Other (Specify) _____

Male / Female (Circle One) Is your pet spayed or neutered? Yes / No (Circle One)

Birth Date _____ Estimated Age if Date of Birth Unknown _____

Breed _____ Color _____ Microchip Number _____

My Pet Came From (Circle One): Friend / Breeder / Pet Shop / Humane Society / Rescue

Describe Your Pet's Diet: _____

Current Medication/Supplements: _____

Does Your Pet Live (Circle One): Indoors / Outdoors / Both

Please List Known Medical Problems/Concerns: _____

Please Check Any Symptoms or Problems You've Noticed With Your Pet:

Appetite Loss Gagging Sneezing Thirst Behavioral Changes

Bleeding Gums Limping Vomiting Coughing Breathing Problems

Loss of Balance Depression Scooting Diarrhea Increased Urination

Weakness Scratching Shaking Head Eye Disorders

Other: _____

Did you bring your vaccination history with you? Yes / No

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 the animal. I also understand that all professional fees are due at the time services are rendered.

Signature of Client _____ Date _____