



WINDSOR PARK VETERINARY CLINIC

Your Neighborhood Veterinarian

REGISTRATION

Owner's Name: (First and Last) _____	Spouse/ Co-Owner: (First and Last) _____		
Address: (City, State, Zip) _____			
Street Address _____	City _____ State _____ Zip _____		
Home Phone: _____	Cell Phone: _____		
Email Address: _____			
How did you hear about us? <input type="checkbox"/> Emancipet <input type="checkbox"/> Yelp <input type="checkbox"/> Google <input type="checkbox"/> Other (Specify)			
In Case of Emergency Please Call	Name: (First and Last) _____	Phone: _____	Relation: _____

**** PLEASE LET OUR STAFF KNOW IF ANY PETS ARE DIFFICULT TO HANDLE ****

PET HEALTH HISTORY

Pet Name: _____	<input type="checkbox"/> Dog	<input type="checkbox"/> Cat		
Breed: _____	Color: _____	Birth date: _____		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Spayed/Neutered	<input type="checkbox"/> Intact	
Microchip Number: _____	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not Chipped		
Name of hospital that your pet was last vaccinated (Please include dates and type of vaccine): _____				
Pet's Current medications: _____				
Describe your pet's diet: _____				
Please check (X) any symptoms or problems that you have with your pet:				
<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Coughing	<input type="checkbox"/> Lack of Appetite	<input type="checkbox"/> Scooting	<input type="checkbox"/> Shaking Head
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Limping	<input type="checkbox"/> Scratching	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Eyes Bulging or Bloodshot	<input type="checkbox"/> Gagging	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Seems Depressed	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Increase in Thirst and/or Urination	<input type="checkbox"/> Weakness	<input type="checkbox"/> Breathing Problems		
<input type="checkbox"/> Other: _____				

AUTHORIZATION

Social Media Release - Do you grant permission to Windsor Park Veterinary Clinic to post photos of your pet onto their website and/or social media forums? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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: _____	Date: _____
Method of Payment: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover <input type="checkbox"/> CareCredit <input type="checkbox"/> Cash	
We Do Not Accept American Express	