

Linganore Veterinary Clinic
 11717 Old National Pike Ste. 12
 New Market, MD 21774



WELCOME

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!

REGISTRATION

TODAY'S DATE _____

OWNER'S NAME _____ SPOUSE/OTHER _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SS #/SIN _____ DRIVERS LICENSE # _____ E-MAIL _____

EMPLOYER'S NAME & ADDRESS _____

SPOUSE'S/OTHER'S EMPLOYER & ADDRESS _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

IN CASE OF **EMERGENCY**, PLEASE CALL _____

PLEASE DESCRIBE OTHER ANIMALS IN HOUSEHOLD _____

REASON FOR VISIT _____

PET HEALTH HISTORY

PET'S NAME _____ DATE OF BIRTH _____

TYPE OF ANIMAL DOG CAT OTHER _____

SEX: MALE NEUTERED FEMALE SPAYED

BREED _____ COLOR _____ WEIGHT _____

VACCINATION HISTORY (Date and type of last vaccinations) _____

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"/> Thirst and/or Urination Increased
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Coughing	<input type="checkbox"/> Scooting	<input type="checkbox"/> Weakness
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Scratching	<input type="checkbox"/> Weight Problem
<input type="checkbox"/> Eye Bulging or Bloodshot	<input type="checkbox"/> Seems Depressed	<input type="checkbox"/> Other _____
<input type="checkbox"/> Gagging	<input type="checkbox"/> Shaking Head	_____

CURRENT MEDICATIONS, IF ANY _____

DESCRIBE YOUR PET'S DIET _____

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 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 of Owner _____ Date _____

Method of payment Cash Check MasterCard VISA Other _____