Huron East Animal Hospital

A4-1606 Battler Rd
Kitchener, ON N2R 0C9
519-895-8883

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: **Date:** ____________
Address:
Postal Code: **Email:** ____________
Home Phone: ____________ **Cell Phone:** ____________
Secondary Owner: ____________ **Relation to owner:** ____________
Secondary's Number: ____________
How did you learn about our clinic? ☐ Sign Outside ☐ Facebook ☐ Recommendation ☐ Website ☐ 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: ______ **Colour:** ______ **Birthdate:** ______
☐ Undetermined ☐ Male ☐ Neutered ☐ Female ☐ Spayed
Vaccination History (date and type of last vaccinations): ____________

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Please check (✓) any symptoms or problems that you have noticed about your pet:

☐ Behavioral Problems	☐ Lack of Appetite	☐ Sneezing
☐ Bleeding Gums	☐ Limping	☐ Thirst and or Urination Increased
☐ Breathing Problems	☐ Loss of Balance	☐ Vomiting
☐ Coughing	☐ Scooting	☐ Weakness
☐ Diarrhea	☐ Scratching	☐ Other: ______
☐ Eye Bulging or Bloodshot	☐ Seems Depressed	☐
☐ Gagging	☐ Shaking Head	☐

Pet's current medications: ____________
Describe your pet's diet: ____________
Previous Clinic: ____________ **May we call for records?** ☐ Yes ☐ No

Authorization

I hereby authorize the veterinarian to examine, prescribe for, and treat my animal(s). I assume all responsibility for all charges incurred in the care of my animals. I understand that payment is **due at the time of service**. I have read and understand the policy and accept responsibility for all fees. I understand that if I fail to pay agreed fees, legal action will be taken against me. All charges not paid in full within 30 days will collect interest of 1.75% per month. By providing your email and signing this document you are consenting to email communications with the clinic.

Signature of Owner: ____________ **Date:** ____________