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: _____

Address: _____ **Apt/Unit #:** _____ **City:** _____

Postal Code: _____ **Email:** _____

Home Phone: _____ **Cell Phone:** _____

Secondary Owner: _____ **Prefered Notifications: Text** ☐ **or Email** ☐

Secondary's Number: _____ **Relation to Owner:** _____

How did you learn about our clinic? ☐ **Sign Outside** ☐ **Facebook** ☐ **Website** ☐ **Recommendation** ☐ **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:** _____ **DOB / ~Age:** _____

☐ **Undetermined** ☐ **Male** ☐ **Neutered** ☐ **Female** ☐ **Spayed**

Vaccination History (date and type of last vaccinations): _____

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

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

Pet's current medications and/or Illness(es): _____

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:** _____