Welcome to Western Trails Veterinary Hospital

Thank you for giving Western Trails Veterinary Hospital the opportunity to care for your animal. We'll be happy to answer any questions you have about your animal's health. To ensure the best care possible, please take the time to fill in this form completely. Thank you.

Registration

Owner's Name: _____ Spouse/Other: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Driver's License Number and State: _____ SSN: _____

Employer: _____

How did you hear of us? _____

Animal Health History

Name: _____ Date of Birth or Age: _____

Species: ____Cat ____ Dog ____Horse ____ Cow ____Other, list species: _____

Sex: ____ Male ____Neutered ____Female ____Spayed

Breed: _____ Color: _____

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

_____

Reason for visit: _____

Please check any symptoms or problems that you have noticed about your animal:

____ Bad Breath	____Eyes Bulging or Bloodshot	**____ Shaking Head**
____ Behavior Problems	**____ Lack of/Change in Appetite**	**____ Seems Depressed**
____ Bleeding Gums	**____ Limping**	**____ Sneezing**
____ Breathing Problems	**____ Loss of Balance**	**____ Thirst and/or Urination Changes**
____ Coughing/Gagging	**____ Scooting**	**____ Vomiting**
____ Diarrhea	**____ Scratching**	**____ Weakness**

____ Other: _____

Current Medications: _____

Previous Clinic where records can be obtained: _____

Describe your animal diet:_____

Authorization: I hereby authorize the veterinarian to examine, prescribe for, or treat the above described animal. I assume responsibility for all charges incurred in the care of this animal. I understand that these charges must be paid at the time of release and that a deposit may be required for surgical treatment and/ or hospitalization.

Signature of Owner/Agent: _____ Date: _____