VETERINARY SURGICAL CENTERS

Client/Patient Registration Form

DATE_____ **Client#** _____

Client Registration

Owner _____

Address_____

City _____ State _____ County_____ Zip _____

Cell _____ Home _____ Work_____

Email _____

Secondary Contact_____ Cell _____

☐ Active Military (must provide military ID)

How did you hear about us?

☐ Friend/Family_____

☐ Event_____

☐ Magazine_____

☐ Google ☐ Yelp ☐ Facebook

☐ Internal Referral

☐ Veterinary Professional:

Veterinarian Name: _____

Hospital Name: _____

☐ Other_____

_____

Patient Registration

Name of Pet _____ Nickname_____

Species _____ Breed _____ Color _____

Date of Birth _____ Sex _____

Is your pet ☐ Indoor ☐ Outdoor

Cats: FIV/Felv tested? ☐ Yes ☐ No If so, when_____ Results_____

Cats/Dogs: Heartworm tested? ☐ Yes ☐ No If so, when_____ Results_____

Is your pet allergic to egg? ☐ Yes ☐ No

Does your pet have any allergies? ☐ Yes ☐ No If so, allergic to_____

_____

Primary Care Veterinarian

Veterinarian's Name _____

Hospital Name _____

Phone Number_____

Specialist Seen (Previously)

Veterinarian's Name _____

Hospital Name _____

Phone Number_____

Specialist Seen (Previously)

Veterinarian's Name _____

Hospital Name _____

Phone Number_____

Specialist Seen (Previously)

Veterinarian's Name _____

Hospital Name _____

Phone Number_____

Pet History

Why are we seeing your pet today?_____

_____

_____

Have radiographs been taken for this current condition? ☐ Yes ☐ No

If yes, where?_____

_____

Has your pet had recent bloodwork within the last 6 weeks? ☐ Yes ☐ No

If yes, where?_____

_____

Please mark any signs or problems you have noticed in your pet:

☐ Skin Problems	☐ Increased Thirst	☐ Breathing Problems
☐ Staring into Space	☐ Increased Urination	☐ Coughing/Gagging
☐ Exercise Intolerance	☐ Diarrhea/ Vomiting	☐ Wheezing
☐ Fainting/Collapsing	☐ Change in Appetite	☐ Tongue turning blue
☐ Weakness	☐ Weight Loss	☐ Bleeding Problems
☐ Loss of Balance	☐ Allergies	☐ Limping: ☐ Right ☐ Left ☐ Back ☐ Front
☐ Difficulty on Stairs	☐ Trouble Sleeping	☐ Difficulty Getting Up/Down
☐ Loss of Muscle Mass	☐ Seizure	☐ Circling/Pacing

Has your pet had any previous surgeries? ☐ Yes ☐ No

If yes, please list:_____

_____

_____

Has your pet had any previous complications with anesthesia? ☐ Yes ☐ No

If yes, please describe:_____

_____

_____

Please list all current medications below:

Medication Name	Dose Given	Frequency	Doctor Prescribed By

What is your pet's current diet?

When was your pet's last meal given? Date Time

Are you aware of any metal such as implants or hardware or in your pet? ☐ Yes ☐ No If Yes, describe:

_____

_____