



Snake River Veterinary Center, PA

Welcome to Our Hospital

Owner Information

Owner: _____ SSN or DL # _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different from street address): _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____

E-mail Address: _____

E-mail me reminders about my pet
(vaccinations, wellness checkups, etc.)

E-mail me news & updates
(news, changes, promos, etc.)

Please Note our Website:
www.snakerivervet.com

Spouse/Other Information:

Name: _____ Work #: _____ Cell #: _____

Employer: _____

How did you learn of our practice? (please check all that apply)

Yellow Pages

Newspaper

Referral

Other _____

Outdoor Sign

Website

Whom may we thank for
recommending our practice?

Pet Information

Pet's Name: _____

Species: _____

Breed: _____

Sex: _____

Spayed/Neutered? _____

Dog Cat

M

Y N

Other _____

F

If yes, when? _____

Date of Birth or Age: _____

Color/Distinctive Markings: _____

Pet Health History

Does your pet have any chronic health problems we should know about?
(kidney disease, heart condition, arthritis, diabetes, etc.)

Please describe: _____

Is your pet currently on medication or a special diet?

Please describe: _____

Has your pet's behavior changed in any way? (please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Sleeping More | <input type="checkbox"/> Foul Breath | <input type="checkbox"/> Coughing or Sneezing |
| <input type="checkbox"/> Drinking More | <input type="checkbox"/> Increased Irritability | <input type="checkbox"/> More Frequent Defecation |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> More Frequent Urination | <input type="checkbox"/> Other (Please describe) |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of Appetite | _____ |

When was your pet's last? (please write the date for each)

Fecal check for intestinal worms? _____

Rabies vaccination? _____

Canine (Dog)

Distemper/Hepatitis/Leptospirosis/
Parinfluenza/Parvovirus vaccination? _____

Bordatella vaccination? _____

Heartworm check? _____

Feline(Cat)

Distemper/Upper Respiratory vaccination? _____

Feline Leukemia and/or AIDS test? _____

Feline Leukemia and/ or AIDS vaccination? _____

Has your pet had any other vaccinations not listed here? _____

Other Pets in Household

Pet's Name	Species and Breed	Sex	Spayed or	Neutered?	Date of Birth or Age
	<input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other _____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	If Yes, when? _____	
	<input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other _____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	If Yes, when? _____	
	<input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other _____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	If Yes, when? _____	

I assume full responsibility for all charges incurred for the services provided by Snake River Veterinary Center. **I understand that these charges are required to be paid at the time of service or release and that a deposit may be required for surgical treatment.** I understand that if these charges are not paid, or if payment by check results in insufficient funds, the amount owed may be turned over to a collection agency for collection and I will be liable for all collection costs and fees, up to and including attorney fees and court costs.

I have read, understand and agree to this statement.

Client Signature: _____ Date: _____

Horses

Horse'sName	Breed	Sex (gelding, mare, stallion)	Date of Birth or Age	Primary use (trail riding, performance, breeding, etc.)

Livestock

Species	# of head	Purpose (4H/FFA, food producing, etc.)