INTERNAL MEDICINE REGISTRATION FORM

Thank you for providing us with the opportunity to care for your pet. In order to insure the best care possible, please take time to verify and fill out this form completely. Thank you!

Owner(s) Name(s): ____Date: _______________
Address: ____City/State:_______________Zip:__________
Home Phone #: ______________________________Work #: ____________________Cell #:__________________
E-Mail Address: ____

Telephone number at which you can be reached today: ____

Who is your regular Veterinarian/Clinic: ____

Is this your first visit to our clinic? ❑ Yes ❑ No
Have we ever seen any of your others pets? ❑ Yes ❑ No

PET HEALTH HISTORY

Name of Pet: ____________________Age: ________Breed: _____________________Color: ___________

Dog or Cat? _____________________Male or Female? _________________Spayed or Neutered?_________

Reason for visit? ____

Patient's out of town travel history, in the last 3 years? ____

Pet's current medications (please include dosage and frequency): ____
____

Pet's diet (include frequency and amount fed): ____

When was your pet last fed? ____

Does your pet stay indoors, outdoors or both? ❑ Indoors ❑ Outdoors ❑ Both

Please check any symptoms or problems that you have noticed occurring in your pet.

❑ Loss of appetite	❑ Limping	❑ Excessive Thirst
❑ Behavioral Changes	❑ Loss of Balance	❑ Increased Urination
❑ Breathing Problems	❑ Vomiting	❑ Scooting/Inappropriate Elimination
❑ Coughing	❑ Weakness	❑ Depression
❑ Scratching/Hair Loss	❑ Rapid Weight Loss	❑ Diarrhea
❑ Shaking Head	❑ Gagging	❑ Seizures ❑ Other ________________

When was your pet last vaccinated for:

Dog: Rabies ___________Distemper/Parvo ___________Kennel Cough ____________
Cat: Rabies ___________Distemper _______________Leukemia _______________

Dogs: Is your pet on Heartworm prevention? ❑Yes ❑No Type? __________ Flea prevention? ❑Yes ❑No Type? __________
Cats: Has your pet been tested for FeLv/FIV? __________ Date of testing? ___________ Results? ___________

I, the undersigned, owner of admitted patient, hereby authorize Upstate Veterinary Specialists to administer such treatment as is necessary and are considered therapeutically and/or diagnostically necessary on the basis of findings during the course of the evaluation. I also consent to the administration of such anesthetics as are necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. Furthermore, I assume all financial responsibility for charges incurred to the patient, consent to release of medical information, and authorize direct payment to Upstate Veterinary Specialists. I understand that I am liable for all collection costs, up to 100%, incurred for this account.

Client Signature: ____ Date: ___________________________

Method of payment: Cash Care Credit Credit Card Check Driver's License # : __________________________