



ONCOLOGY 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: _____

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? _____

When was your pet last vaccinated for:

Dog: Rabies _____ Distemper/Parvo _____ Kennel Cough _____
Cat: Rabies _____ Distemper _____ Leukemia _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Limping | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Behavioral Changes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Increased Urination |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Scooting/Inappropriate Elimination |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Weakness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Scratching/Hair Loss | <input type="checkbox"/> Rapid Weight Loss | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Shaking Head | <input type="checkbox"/> Gagging | <input type="checkbox"/> Seizures <input type="checkbox"/> Other _____ |

I, the undersigned, owner of admitted patient, hereby authorize Upstate Veterinary Specialists to administer such treatment as is necessary and are considered therapeutically 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 CitiHealth Credit Card Check Driver's License # : _____