SANTA CRUZ VETERINARY CLINIC
5408 S. 12th Ave. Tucson, AZ 85706
Phone #: (520) 889-9643
Fax #: (520) 889-9023
www.santacruzpet.com

CLIENT REGISTRATION FORM

PLEASE USE BLACK OR BLUE INK AND PRINT LEGIBLY

Client Name: _____
Mailing Address:_____
Street Apt/Unit#
_____
City State Zip
Physical Address:_____
Street Apt/Unit#
_____
City State Zip
Phone #: **Primary:**_____
Other: _____
E-mail: _____

Patient Name: _____
Species: ❑ **Dog** ❑ **Cat** **Other** ❑_____
Sex: ❑ **Male** ❑ **Female** **Spayed/Neutered?** ❑**Yes** ❑**No**
DOB: ___/___/____ Age: _____ **wks/mo/yrs**
Breed: _____
Color: _____
Microchip#: _____ ❑**None**

Emergency contact if owner cannot be reached:

Name: _____ Name: _____
Phone #: _____ Phone #: _____

Patient History:

1. Where did you get your pet? _____ 2. How long have you owned your pet? _____
3. Does your pet have any current or recent illness or injuries?❑No ❑Cough ❑Sneeze ❑Vomiting ❑Diarrhea ❑Other: _____
4. Is your pet eating and drinking normally? ❑Yes ❑No:Explain:_____ Brand/Type of food? _____
5. Has your pet ever had an allergic reaction to a vaccination or medication? ❑Yes ❑No: Explain:_____
6. Is your pet currently taking any medication? ❑Yes ❑No: Type/Dosage:_____
7. FEMALES ONLY: Number of litters _____ Date of last litter _____ Date of last heat _____
8. Has your pet been vaccinated? ❑No If Yes: **Dogs:** Parvo ___/___/___ INAPB ___/___/___ Rabies ___/___/___
   ❑No proof of vaccines but current per owner **Cats:** PRC___/___/___ FeLV ___/___/___ Rabies ___/___/___

What is the reason for your visit today?

_____
_____
_____

Permission to treat:

I am the owner and/or designated person to authorize for medical care for the above described pet. I hereby allow Santa Cruz Veterinary Clinic to examine, prescribe for, and/or treat the above described pet. I assume all responsibility for charges acquired in the care of this animal. I also understand that these charges will be paid at time services are rendered and deposit may be required for inpatient care. If the above described pet is receiving services that are paid for by any organization, then I understand the pet must be surgically sterilized (spay/neuter) at this time. If inpatient care is required understand that personnel are not present on premises 24hrs a day. I understand that if my account is not kept in good standing my account may be forwarded to a third party collections and it may negatively affect my credit. I understand that in the event of any unusual or emergency circumstances doctors and staff will use all reasonable precautions against injury, escape, or death of my pet.

Signature: _____ **Print Name:** _____ **Date:** _____

How did you hear about us? ❑Friend/Family ❑Online:_____ ❑Other:_____

TECH CHECK IN NOTES:
Wt: _____lb T: _____E/R P:_____ R: _____

DATA ENTRY
Staff Initials: _____