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 UES BLACK OR BLUE INK AND PRINK 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:_____________________________ 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 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:** _______

TECH CHECK IN NOTES:
Wt: ______lb T: ______E/R P:_____ R: _____

DATA ENTRY
Staff Initials: ______