



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: _____	Patient Name: _____
Mailing Address: _____ Street Apt/Unit#	Species: <input type="checkbox"/> Dog <input type="checkbox"/> Cat Other <input type="checkbox"/> _____
City State Zip	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Spayed/Neutered? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Address: _____ Street Apt/Unit#	DOB: ___/___/___ Age: _____ wks/mo/yrs
City State Zip	Breed: _____
Phone #: Primary: _____	Color: _____
Other: _____	Microchip#: _____ <input type="checkbox"/> None
E-mail: _____	

Emergency contact if owner cannot be reached:

Name: _____
Phone #: _____

Name: _____
Phone #: _____

Patient History:

- Where did you get your pet? _____
- How long have you owned your pet? _____
- Does your pet have any current or recent illness or injuries? No Cough Sneeze Vomiting Diarrhea Other: _____
- Is your pet eating and drinking normally? Yes No: Explain: _____ Type of food? _____
- Has your pet ever had an allergic reaction to a vaccination or medication? Yes No: Explain: _____
- Is your pet currently taking any medication? Yes No: Type/Dosage: _____
- FEMALES ONLY: Number of litters _____ Date of last litter _____ Date of last heat _____
- 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: _____