



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.

- | | | |
|---|--|---|
| <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 _____ |

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 # : _____