Brevard Veterinary Hospital

Caring for your pets as if they were our own.

Thank you for giving us the opportunity to care for your pet.

So that we may be better able to meet your needs, please complete the following:

REGISTRATION:

Date_____ Owner_____

Address_____ City_____ State_____ Zip_____

Email Address_____ Employer_____

Home Phone_____ Cell Phone_____ Work Phone_____

Spouse_____ Spouse Work Phone_____

How did you learn about our clinic? □ Yellow Pages □ Recommendation □ Sign □ Online □ Other_____

If recommended, by whom? _____

Number of Pets: Dogs_____ Cats_____ Other (specify)_____

Reason for Visit_____

Where did you obtain this pet? □ Breeder □ Pet Store □ Humane Society □ Other_____

At what age was this pet obtained? _____ In case of emergency, whom should we contact?

Name_____ Phone_____

PET HEALTH HISTORY:

Name of Pet _____ □ Dog □ Cat Breed_____

Color _____ Age/Birth Date_____ Gender: □ Male □ Female

Neutered/Spayed □ Yes □ No If so, at what age? _____

Vaccination History (date/type of last vaccs.) _____

Prior Surgery _____ Prior Illness_____

Pet's Current Medications_____

Describe Your Pet's Diet_____

AUTHORIZATION:

Our policy is that all medical records are kept CONFIDENTIAL. However, in certain instances, other providers request medical information (i.e. vaccine history for boarding) and by signing this you authorize Dr. Kimberly Jennings and Brevard Veterinary Hospital staff to disclose such information to the requesting party. If you do not sign below, NO information will be given to ANY third party.

Client Signature or Person Responsible for Pet_____

I hereby authorize the Veterinarian to examine, prescribe for, and/or treat the above-described pet. I assume full responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. We will gladly give an estimate first.

To prevent the spread of infectious diseases, all hospitalized patients must be current on all vaccines and free from internal and external parasites. The signature below authorizes this level of preventive care and the appropriate charges will be assessed on the discharge invoice.

Signature_____ Date_____