Welcome to Cape May Veterinary Hospital

Thank you for giving us the opportunity to care for your pet. We will be happy to answer any questions you have about your pet's health. ***To insure the best care possible, please take the time to fill in this form completely.*** Thank you.

Owner's Name: _____ SS#_____

Owner's Date of Birth: _____

Address: _____City: _____State: _____ Zip: _____

Spouse/Other: _____ SS#_____

Primary Phone: _____ Alternate Phone: _____ Work Phone: _____

E-Mail Address: _____

Employer's Name & Address: _____

Emergency Contact Name: _____ Phone: _____

How did you hear about our hospital?

Individual, someone we may thank? _____
Yellow Pages? _____
Another hospital? Which? _____
Other, please state_____

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PET HEALTH HISTORY

Name of pet: _____ □ Dog □ Cat Other: _____

Breed: _____ Color: _____ Birth date: _____

Please circle one: MALE NEUTERED or FEMALE SPAYED

Please list vaccination history **(UNLESS RECORDS HAVE BEEN PROVIDED)**

Date and type of last vaccinations: _____

Do you require a mailed vaccine reminder? □ Yes □ No

Please check any symptoms or problems that you have noticed about your pet:

Behavior Problem	Lack of Appetite	Sneezing
Bleeding Gums	Limping	Thirst and/or Urination Increased
Breathing Problems	Loss of Balance	Vomiting
Coughing	Scooting	Weakness
Diarrhea	Scratching	Other_____
Gagging	Seems Depressed	_____
Eyes Bloodshot	Shaking Head	

Pet's Current Medications: _____

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in 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.

Signature of Owner: _____ Date:_____