New Patient Registration Form

Welcome to our clinic! We appreciate the opportunity to care for your pet. Please help us to better meet your pet's needs by taking a moment to share some important information.

Owner's Name: _____ Spouse/Co-Owner/Other: _____
(Mr., Miss, Mrs., Ms., Dr.) Last First Last First

Home Address: _____

City, State, ZIP Code: _____ County: _____

Home Phone Number: _____ Cell Phone Number: _____

Secondary Phone Number: _____ Email Address: _____

Employer: _____ Work Phone Number: _____

How did you hear about our practice? Please check all that apply.

☐ Personal Referral – Who may we thank for referring you? _____
☐ Hospital Sign/Clinic Location
☐ Chamber of Commerce
☐ Yellow Pages
☐ Internet Search
☐ Teegarden Veterinary Clinic's Webpage
☐ Teegarden Veterinary Clinic's Facebook Page
☐ Newspaper/Print Media
☐ AAHA Referral

How many pets are in your household? _____

Please list the names and contact information of those who have authorization to approve treatment to the patient(s) named below:

_____

ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. We will gladly prepare a written estimate if you desire. Please just ask the receptionist, technician, or doctor. In the event the bank does not honor your written check, we automatically route the dishonored check to a collection agency. You will be charged the full amount of the check and any accrued bank charges/ accounting/ service fees; there will be an additional $25.00 accounting/service fee for any dishonored check. When **any** account is turned over for collections, all costs of collection (including reasonable collection fees, attorney's fees, and court costs) will be added to the outstanding balance.

Signature _____ **Date** _____

TEEGARDEN VETERINARY CLINIC PC

Patient Information

Patient's Name: _____ Date of Birth: _____

Species: _____ Breed: _____

Sex: _____ Neutered/Spayed? Yes or No

Description/Color: _____ Length of Time Owned: _____

Pet's Origin (please check one):

☐ Humane Society - Name: _____ ☐ Friend ☐ Advertisement

☐ Pet Store - Name: _____ ☐ Stray

☐ Kennel - Name: _____ ☐ Breeder

Hours spent outside each day: _____ Diet (food currently fed): _____

Reason for today's visit: _____

Any known medical conditions, allergies, or drug reactions? _____ If yes, please list: _____

_____

What vaccinations have previously been given and dates given? _____

_____

Please circle YES or NO; explain if needed.

1) Has your pet had any medical problems? YES NO _____
2) Does your pet have any chronic medical issues? YES NO _____
3) Does your pet have any allergies? YES NO _____
4) Is your pet on any medications or supplements? YES NO _____
   Dosage and frequency? _____
5) Has your pet traveled out of state? Where? YES NO _____
6) Was your pet tested for heartworm disease within the last year? YES NO
7) Is your pet given heartworm preventative? YES NO _____
8) Has your pet's stool been tested within the last year? YES NO

Please check any of the following signs or symptoms your pet has shown and indicate the duration:

☐ Bad Breath	☐ Body odor	☐ Coughing
☐ Sneezing	☐ Head Shaking	☐ Gagging
☐ Vomiting	☐ Ear Problems	☐ Eye Problems
☐ Itching/Scratching	☐ Lameness/Stiffness	☐ Lumps/Bumps
☐ Tremors/Seizures	☐ Lethargy/Weakness	☐ Skin Problems
☐ Diarrhea	☐ Unusual Discharge	
☐ Poor Hair Coat or Hair Loss	☐ Scooting or Licking Rear End	

Has your pet shown significant change in any of the following? Please check yes or no.

1) Character of bowel movements?	☐ YES	☐ NO
2) Frequency or amount of urination?	☐ YES	☐ NO
3) Weight gain or loss?	☐ YES	☐ NO
4) Activity level?	☐ YES	☐ NO
5) Appetite?	☐ YES	☐ NO
6) Drinking?	☐ YES	☐ NO
7) Behavior?	☐ YES	☐ NO
8) Attitude?	☐ YES	☐ NO

Could your pet have eaten anything not consistent with their regular diet? (poison, garbage, table food, ect.) ☐ NO ☐ YES _____

Is there anything else that you feel we should know? _____

Your pet is very important to us. If you are transferring services from a previous veterinarian, please contact your previous veterinarian and request your pet's medical records. This will help us to be able to provide the best care for your pet. Your pet's records can be faxed directly to us at (309) 444-8427.

Please list the name and address of any veterinary hospital(s) at which your pet(s) is/was a patient:

_____

You may download and print this form before your initial visit to shorten the registration process. Please bring the completed form with you to your pet's appointment.

Thank you again for entrusting the staff of Teegarden Veterinary Clinic with your pet's care. Our goal is to provide quality comprehensive care for pets to enhance their well-being and quality of life.