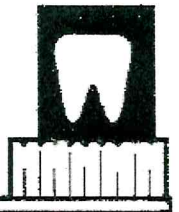




The Standard of Veterinary Excellence



Bridgton Veterinary Hospital & Dental Care Center



213 Harrison Road, Bridgton, ME 04009 Phone: 207-647-8804 Fax: 207-647-5199 Email: office@bridgtonvets.com

Welcome

We know your pet's health is important and we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form completely. Thank You!

REGISTRATION

Owner: _____ Date: _____
 Address: _____ Employer: _____
 City, State, Zip _____
 Co-Owner: _____
 Phone: _____ Work Phone: _____ Cell Phone: _____
 E-Mail: _____
 Emergency Contact Name: _____ Phone _____
 How did you learn about our clinic? Sign Outside Yellow Pages Facebook Recommendation
 Website News Paper Other: _____
 If recommended, by whom? _____
 Number of Pets Dogs: _____ Cats: _____ Other (Specify): _____
 Reason for Visit: _____

PET HEALTH HISTORY

Name of Pet: _____ Dog Cat Other: _____
 Breed: _____ Color: _____ Birthdate: _____
 Male Female Neutered Male Spayed Female
 Vaccination History (date and type of last vaccinations): _____

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Limping | <input type="checkbox"/> Thirst and or Urination Increased |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Scooting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Seems Depressed | <input type="checkbox"/> |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Shaking Head | <input type="checkbox"/> |

Pet's current medications: _____
 Describe your pet's diet: _____

AUTHORIZATION

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.

Signature of Owner:* _____ Date: _____
 Method of Payment: Cash Check Mastercard Visa Other: _____

*Must be 18 years of age or older