



WELCOME

Thank you for giving us the opportunity to care for your pet. We'll 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!

REGISTRATION – ALOHA ANIMAL MEDICAL CENTER 503-591-8625 Fax 503-649-0478

Primary Owner (must be 18 or over) _____ Date _____

Co-owner/Spouse _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Cell Phone #2 _____

Employer _____

Emergency Contact Name _____ Phone _____

How did you hear about us?

- google
 website
 walk/drive by
 internet search
 Recommendation by _____ Other (specify) _____

Number of pets: Dogs ____ Cats _ Other (specify) _____

PET HEALTH HISTORY

Name of Pet _____ Dog Cat Other _____

Breed _____ Color _____ Birth-date _____

Male Neutered Female Spayed

Name of Pet _____ Dog Cat Other _____

Breed _____ Color _____ Birth-date _____

Male Neutered Female Spayed

Reason for visit _____

Pet's current medications _____

Pet's current diet _____

AUTHORIZATION

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 _____

Methods of Payment accepted: Cash, VISA, Mastercard, American Express, Discover card and CareCredit.