WELCOME TO WESTARBOR ANIMAL HOSPITAL

We are honored that you chose our staff to care for your valued family member

PET INFORMATION:

Pet's Name_____ Sex_____ Spayed/Neutered? _____
Age/Birthdate_____ Species_____Breed_____Color_____

PLEASE CHECK ANY SYMPTOMS OR PROBLEMS YOU HAVE OBSERVED WITH YOUR PET:

□Appetite loss	□Gagging	□Sneezing	□Depression
□Behavioral Changes	□Gums Bleeding	□Thirst	□Scooting
□Breathing Problems	□Limping	□Urination Increase	□Weakness
□Coughing	□Loss of Balance	□Vomiting	□Diarrhea
□Scratching	□Eye Disorders	□Shaking head	□Other:_____

CURRENT OBSERVATIONS THAT YOU WISH TO DISCUSS:

_____
_____

BEHAVIOR ISSUES THAT YOU WISH TO DISCUSS WITH THE VETERINARIAN AT TODAY'S VISIT:

_____
_____

ADDITIONAL PET:
Pet's Name_____ Sex_____ Spayed/Neutered? _____
Age/Birthdate_____ Species_____Breed_____Color_____

Social Security Number **or** Driver's License_____
(REQUIRED BY THE STATE OF MICHIGAN TO DISPENSE MEDICATION)

HOW DID YOU LEARN ABOUT OUR HOSPITAL: (Circle one)
Sign/Location/Yellow Pages/Referral/Newspaper/Internet

NAME OF THE PERSON WHO REFERRED YOU TO OUR HOSPITAL:_____

AUTHORIZATION:
I hereby authorize the veterinarian to examine, prescribe for, or treat the above pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICES RENDERED.

Signature of client responsible for pet(s) _____Date_____

METHOD OF PAYMENT: (Circle one) Cash Check Visa MasterCard Discover Care Credit
Payment is expected at the time of service. We do not bill unless prior arrangements have been made.

Authorized Owner **(must be 18 years of age or older)**_____
(Last) (First) (Middle)
And/Or Spouse/Partner _____
(Last) (First) (Middle)
Address_____

City/State/Zipcode_____

Email Address_____

Home Phone_____Cellphone_____

Work Phone_____

Emergency Contact if we can't reach you_____

ENTERED BY: _____ **ENTIRE FORM ENTERED: Y / N**