Schulhof Animal Hospital
WELLNESS CENTER AND PET SPA
199 Post Road West
Westport, CT 06880
(203) 226-1231
schulhofanimalhospital.com

# NEW PATIENT REGISTRATION

| Owner's name, Last | Owner's name, First | Spouse/Partner's Name, Last | Spouse/Partner's Name, First |
|---|---|---|---|
| Home Phone | Business Phone | Cell Phone/Emergency Phone | Partner's Work Phone |

| Address | City, State, Zip | E-mail |
|---|---|---|

| SS# | Employer/Business | Address |
|---|---|---|

| Patient's Name | Species:<br>Dog___ Cat___ Other___ | Sex:<br>Male ____ Altered Male ____ Female _____ Spayed Female ____ |
|---|---|---|

| Breed | Color | Birthdate |
|---|---|---|

Date of Last Vaccinations:
Rabies _____ Feline/K9 Distemper _____ Bordetella _____ Lyme _____ Lepto _____ FeLV _____

| Previous Major Health Problems | Known Drug or Vaccine Allergies |
|---|---|

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

| | | | |
|---|---|---|---|
| ___ Behavior Problems | ___ Bleeding Gums | ___ Breathing Problems | ___ Coughing |
| ___ Diarrhea | ___ Eyes Bulging or Bloodshot | ___ Gagging | ___ Limping |
| ___ Scooting | ___ Lack of Appetite | ___ Loss of Balance | ___ Scratching |
| ___ Seems Depressed | ___ Shaking Head | ___ Sneezing | ___ Vomiting |

___ Aggression toward people/animals ___ Thirst and/or Increased Urination ___ Other _____

| Is your dog/cat now taking heartworm preventative?<br>Yes _____ No _____ | Do you have children?<br>Yes _____ No _____ |
|---|---|

How will you pay for this visit today?
CASH _____ CHECK* _____ M/C, VISA _____
*only with valid dr. lic. & have been a client over 6 months

Please tell us how you found out about us (check any that apply): ☐ on-line directory (which site _____)
☐ yellow pages ☐ direct mailing ☐ newspaper ☐ magazine ☐ rabies clinic ☐ SAH web page ☐ drive by
☐Humane Society ☐ Special Event ☐ Professional Referral ☐ other _____
☐ friend* _____ *Please give name so we can send them a 'Thank You.'

The above information is accurate and true to the best of my knowledge and 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, and that these charges will be paid at the time of release. I understand that a credit card number with expiration date and a deposit will be required for surgical treatment or major procedures. In the event of payment default I will pay reasonable attorney's fees and costs of collection. If payment becomes 30 days past due, service charges at an APR of 18% and a $5.00/month billing fee will be added to the balance due.

Signature of Owner _____ Date _____