



**OCONEE
VETERINARY
HOSPITAL**

Welcome to Oconee Veterinary Hospital

Practicing Medicine with Compassion and Confidence

Date: ___/___/___ How did you hear about us? _____

Client information:

Owners name: _____

Owner's Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

How will you be paying today? Cash/check/creditcard/carecredit

Pet name: _____ Dog/cat? _____ Breed: _____ Sex :M/F Spay/Neutered?Y/N Age: _____

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Are your pets microchipped? Y/N. This can be done for \$35.50 today with free registration. Y/N

Current medications your pet is taking: _____

Primary Reason for visit today? _____

Symptoms your pet is demonstrating:

<input type="checkbox"/> Appetite loss	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Limping	<input type="checkbox"/> Thirst	<input type="checkbox"/> Other
<input type="checkbox"/> Behavioral changes	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Scratching	<input type="checkbox"/> Urination Increased	
<input type="checkbox"/> Coughing	<input type="checkbox"/> Gagging	<input type="checkbox"/> Shaking head	<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Depression/lethargy	<input type="checkbox"/> Eye Disorders	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Weakness	
<input type="checkbox"/> Eating more	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Scooting	<input type="checkbox"/> Shivering	

Authorization:

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume full responsibility for all charges incurred in the care of my pet. I also understand that all fees are due at the time services are rendered.

Signature of responsible party: _____ Date: ___/___/___

The information on this form is held in strict confidentiality and is only used by this practice to provide care and treatment for your pet. This information is not shared, or sold.