

Welcome!



Welcome to Lakeland Veterinary Hospital! We would like to thank you for giving us the opportunity to care for your pet(s). We'll be happy to answer any questions you have about your pet's health! To insure the best care possible, please take a few minutes to fill out this form completely.

REGISTRATION

Owner(s) _____ Date _____

Address _____ City _____ State _____ Zip _____

Email Address* _____

Primary Phone Number _____ Cell: _____ Work: _____ Home _____
(NAME) (NAME) (NAME)

Additional Phone Numbers _____ Cell: _____ Work: _____ Home _____
(NAME) (NAME) (NAME)

_____ Cell: _____ Work: _____ Home _____
(NAME) (NAME) (NAME)

Places of Employment: _____ (BUSINESS) _____ (OWNER'S NAME)
 _____ (BUSINESS) _____ (OWNER'S NAME)

In case of EMERGENCY, please call _____ (CONTACT NAME) _____ (CONTACT NUMBER(S))

How did you become aware of our hospital? Location Hospital Sign Our Website Humane Society
 Previous Client Recommendation Online Search: _____

If recommended, whom may we thank? _____

PATIENT INFORMATION

Pet's Name			
Species	<input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Other	<input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Other	<input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Other
Breed			
Color(s)			
Date of Birth			
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Altered (Spayed or Neutered)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current on vaccines?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any previous surgery or serious illnesses/disease?			
Any allergies to vaccines or medications?			
Is your pet on any special diets or medications?			

Previous or Regular Veterinarian (Name & Phone): _____

AUTHORIZATION

*Do we have your authorization to email your pet's vaccine reminders or other periodic reminders? Yes No N/A
 Do we have your authorization to fax or verbally transfer records to another veterinarian, boarding or grooming facility, upon their request? Yes No
 I grant LVH permission to post my pet's picture, story and/or medical information on social media (when applicable). Yes No

I hereby authorize the veterinarian to examine, prescribe for or treat the above described pets. I assume responsibility for all charges incurred in the care of these animals. I understand that these charges must be paid at the time of release and a deposit may be required for treatments.

Signature of Owner/Agent _____ Date _____

For your convenience, we accept Cash, Checks, Visa, MasterCard, Discover, American Express and Care Credit