WEST END ANIMAL CLINIC

Dr. Jeff Toman (409) 866-9802 14 Plaza Dr, Beaumont TX 77706

Pet Registration

Thank you for giving us the opportunity to care for your pet. We will be happy to answer any questions that you may have about your pet's health. To ensure the best care possible, please take the time to fill out this form completely (please circle where applicable). Thank you!

Owner _____ Owner Date of Birth _____
Mailing Address _____ City_____ Zip_____
Spouse _____
Home Phone _____ Daytime Phone _____ Cell _____

Email (for reminders) _____
Eligible Discount: Military (Active or Retired) _____ Senior (65+) _____ First Responder _____
Do you plan on using pet insurance? **Yes / No** (Please note we do not file on insurance but it is helpful for us to know if we will be contacted by your insurance company.)

Pet Information

Name of Pet _____ Dog / Cat / Other _____
Reason for Visit _____
Breed _____ Color _____ Birth Date/Age _____
Please circle Sex: **Female / Male** Spayed/Neutered: **Yes / No**

Pet Health History

Has your pet been to the vet for routine wellness care within the past: **1 month / 6 months / 1 year / Unknown**
Previous veterinary provider: _____
Vaccination status: **Current on vaccines / Needs vaccines / Never had vaccines / Unknown**
Is your pet on preventative medications? Heartworm: **Yes / No** Flea/tick: **Yes / No**
Current Medications: **Yes / No Please list**: _____
Food and/or medication allergies/sensitivities: **Yes / No Please list**: _____
Pre-existing conditions: **Yes / No Please list**: _____

Please check any problems that you may have noticed with your pet:

☐ Behavior Problems ☐ Limping ☐ Eye Bulging/Bloodshot ☐ Coughing
☐ Bleeding Gums ☐ Loss of Balance ☐ Vomiting ☐ Scratching
☐ Weakness ☐ Lack of Appetite ☐ Gagging ☐ Increased Thirst
☐ Increased Urination ☐ Scooting ☐ Diarrhea ☐ Depression
☐ Other: _____

Authorization

I hereby authorize the Veterinarian to examine, prescribe, or treat the above animal. I also assume responsibility for all charges incurred and agree to pay all charges at time of treatment. Regular Form of Payment: ___Cash ___Credit Card ___ Care Credit ___ Check

Signature _____ Date _____

New Clients please present driver license to receptionist