



Welcome

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Thank you for giving us the opportunity to care for your pet. We will be happy to answer any questions you have about your pet's health. To ensure the best care possible, please take the time to fill in the form completely. Thank you!

REGISTRATION

Date _____
Owner _____ Email _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Spouse _____ Email _____
Spouse Home Phone _____ Cell Phone _____ Work Phone _____
Emergency Contact Name _____ Phone _____
How did you learn about our clinic? Internet Sign Facebook Newspaper Yellow Pages
 Recommendation – by whom? _____
Owner authorizes NPAC to take pictures and/or videos of your pet(s) for continuing education, medical publications or promotional purposes. **Signature** _____

PET HEALTH HISTORY

Pet Name _____ Dog Cat Other _____
Breed _____ Color _____ Birthdate/Age _____
 Male Neutered Female Spayed
Reason for visit _____
Name of Previous Veterinarian/Veterinary Clinic _____

Please check (v) any symptoms or problems that you have noticed about your pet.

- | | | |
|---|---|--|
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Limping | <input type="checkbox"/> Thirsty/Increased Urination |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Scooting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Wound |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Seems Depressed/Low Energy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Shaking Head | |

Pet's current medications _____
Describe your pet's diet (type of food/amount/frequency) _____

AUTHORIZATION

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 understand that payment is due at the time of service. I also understand that a deposit may be required for surgical treatment.

Signature of owner _____
Method of Payment: Cash MasterCard Visa CareCredit Amex Discover