Dr. Nickel's Animal Hospital
312 Oriskany Blvd., Whitesboro, NY 13492
315-736-2000
Fax: 315-292-5556

REGISTRATION

Owner's name(s):____Date:______________

Address:___________________________________City/State/Zip:________________________________

Home phone:_______________________________Cell phone:_________________________________

Email:____

How do you prefer to be contacted?____

How did you hear about us? Is there someone we can thank?_____________________________________

PET HEALTH HISTORY

Name:______________________________Species: Dog Cat Date of Birth:____________________

Breed:______________________________Sex: M F Neutered Spayed Color:_______________

Current medications:____

Current diet:____

Previous surgeries, illnesses or other health issues:_______________________________________

What is the total number of pets you have in your home?_______________________________________

If you have more than one pet, please fill out the reverse side of this form.
Knowing about all your furry friends helps the veterinarian provide your pets the best care possible.

AUTHORIZATION

In the event that you are unable to bring your pet in for treatment, you may authorize another person(s) to act as your agent(s). That person(s) will have access to your pet's medical record and will be authorized to make decisions about your pet's care in your absence. Please be advised that you, as the owner, will be financially responsible for any decisions made by your authorized agent(s). You may update this information in writing at any time.

AUTHORIZED AGENT NAME	PHONE	RELATIONSHIP TO OWNER

There may be times when your pet's vaccination or medical information may be requested by outside individuals (boarding and grooming facilities, law enforcement, other veterinarians, etc.). Your pet's medical records are protected by law and cannot be released to anyone without your permission.

____I authorize you to release ONLY my pet's **vaccination** information

____I authorize you to release my pet's **vaccination** AND **medical** information

I herby authorize Dr. Nickel to examine and treat the pet(s) described herein. I assume responsibility for all charges incurred and understand that these charges are due at the time of treatment.

OWNER SIGNATURE PRINT DATE

PLEASE SEE REVERSE SIDE FOR **ADDITIONAL PETS** ->>

PET #2 HEALTH HISTORY

Name:_____ Species: Dog Cat Date of Birth:_____

Breed:_____ Sex: M F Neutered Spayed Color:_____

Current medications:_____

Current diet:_____

Previous surgeries, illnesses or other health issues:_____

PET #3 HEALTH HISTORY

Name:_____ Species: Dog Cat Date of Birth:_____

Breed:_____ Sex: M F Neutered Spayed Color:_____

Current medications:_____

Current diet:_____

Previous surgeries, illnesses or other health issues:_____

PET #4 HEALTH HISTORY

Name:_____ Species: Dog Cat Date of Birth:_____

Breed:_____ Sex: M F Neutered Spayed Color:_____

Current medications:_____

Current diet:_____

Previous surgeries, illnesses or other health issues:_____

PET #5 HEALTH HISTORY

Name:_____ Species: Dog Cat Date of Birth:_____

Breed:_____ Sex: M F Neutered Spayed Color:_____

Current medications:_____

Current diet:_____

Previous surgeries, illnesses or other health issues:_____

PET #6 HEALTH HISTORY

Name:_____ Species: Dog Cat Date of Birth:_____

Breed:_____ Sex: M F Neutered Spayed Color:_____

Current medications:_____

Current diet:_____

Previous surgeries, illnesses or other health issues:_____