



## New Patient Registration

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

YOUR NAME:		SPOUSE/CO-OWNER:		
ADDRESS:	APT/UNIT:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:	ALT. PHONE:		ALT. PHONE:	
HOME/WORK/CELL	HOME/WORK/CELL	HOME/WORK/CELL		
EMAIL ADDRESS:		EMERGENCY CONTACT & PHONE NUMBER:		
(PLEASE PRINT)				
Please note: Your privacy is important to us. All information received in all forms and through other communications is subject to our Privacy Policy & Red Flag Law.				
How did you learn about our veterinary center? (Please check all that apply)				
<input type="checkbox"/> Google Ad <input type="checkbox"/> General Web Search <input type="checkbox"/> Facebook <input type="checkbox"/> Home Show <input type="checkbox"/> Pinterest <input type="checkbox"/> Yelp <input type="checkbox"/> Event <input type="checkbox"/> Road Sign <input type="checkbox"/> Drive By <input type="checkbox"/> Newspaper/Magazine <input type="checkbox"/> Dex/Phone Book <input type="checkbox"/> Recommendation <input type="checkbox"/> SAVSEC <input type="checkbox"/> VSCOT <input type="checkbox"/> Referral by another hospital/doctor <input type="checkbox"/> Other _____				
If recommendation/referral, who may we thank?				
INITIALS	<b>PLEASE INITIAL EACH OF THE FOLLOWING:</b>			
	I hereby authorize the veterinarian to examine, prescribe for, or treat my pet (s).			
	I am aware that trained personnel will not be here beyond regular hours.			
	I understand it is my responsibility to inform the veterinary care team with relevant information regarding my pet's health, diet, medications, supplements, and/or treatments. Serious and sometimes fatal consequences can result from result withholding medical information.			
	I am aware that <b>ALL PAYMENTS ARE DUE AT TIME OF SERVICES RENDERED.</b> We accept cash, AZ checks with an AZ ID, CareCredit, Visa, Discover, Mastercard and American Express. P.A.W.S. does not have a payment plan available but we do offer CareCredit through an independent creditor for your convenience.			
	In the event the account is placed for collections and/or litigation, I am aware that I am responsible for all costs.			
	I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and a deposit may be required for drop-off/surgical treatment.			
	I am 18 (or older) and agree by signing below that I am the person responsible for the care and well-being of my pet(s).			
	I am under 18 and/or not the owner of the animal. I am aware that P.A.W.S. provides a Power of Attorney letter that must be signed for me to provide care for the pet(s) being seen today.			
SIGNATURE OF OWNER/CO-OWNER:			DATE:	



## Pet's Information

*\*If bringing in more than one pet for appointment, please fill out a separate form for each pet.\**

PET'S NAME:		AGE/DOB:	
PLEASE CIRCLE ALL THAT APPLY: MALE - NEUTERED    FEMALE - SPAYED		IS YOUR PET MICROCHIPPED? YES / NO	MICROCHIP NUMBER, IF KNOWN:
BREED:	SPECIES:	COLOR:	
LIVED WITH SINCE:	NATIVE TO ARIZONA? YES / NO	IF NOT NATIVE, WHERE BORN?	
APPROXIMATE HOURS SPENT OUTDOORS:  DAILY / WEEKLY		PLACES PET TRAVELS:	
IS YOUR PET ON ANY SUPPLEMENTS OR MEDICATIONS? YES / NO	IF YES, PLEASE LIST: _____ _____ _____		
PREVIOUS MEDICAL ISSUES: _____ _____ _____			
PLEASE LIST ANY KNOWN ALLERGIES TO VACCINES OR MEDICATIONS: _____ _____ _____			
PLEASE LIST ANY RECENT CHANGES IN HOME ENVIRONMENT: _____ _____			
OTHER PETS? YES / NO	IF YES, PLEASE LIST: _____ _____		
<p>If you are a referral patient to PAWS, it is important to note that for all routine care services, including laboratory services, vaccinations, surgeries, and dentistry, will be transferred back to your primary care provider. To facilitate informed and exceptional care for your pet, PAWS Integrative Veterinary Center will contact your primary care veterinarian via fax or phone, summarizing your pet's alternative or rehabilitative evaluation.</p>			
<input type="checkbox"/> I would like my records sent to my primary care veterinarian or hospital.			
My primary care veterinarian or hospital is: _____			
<i>To the best of my knowledge, ALL information about my pet is represented correctly.</i>			
SIGNATURE OF OWNER/CO-OWNER:			DATE:

# Please tell us about your cat's behavior



Today's Date: \_\_\_/\_\_\_/\_\_\_ Client's name: \_\_\_\_\_

Cat's name: \_\_\_\_\_ Cat's date of birth: \_\_\_/\_\_\_/\_\_\_ Is this birth date estimated? known?

Cat's breed: \_\_\_\_\_ Cat's sex: M MC F FS Age at adoption: \_\_\_\_\_ weeks months years

Is your cat: indoor only outdoor only indoor/outdoor

	Yes	No
Do you have any worries, complaints, or problems with urination in the house now?		
Do you have any worries, complaints, or problems with defecation in the house now?		
Does your cat destroy any objects or anything else by chewing, sucking, or eliminating on them (for example, furniture, rugs, clothes, or other objects) now?		
Does your cat mouth, bite, suck, or nip anything or anyone?		
Does your cat make any sounds that worry you?		
Does your cat hiss, growl, or bite?		
Have you ever worried that your cat is aggressive to people?		
Have you ever worried that your cat is aggressive to other cats?		
Have you ever worried that your cat is aggressive to animals other than cats?		
Has your cat ever bitten or clawed anyone, regardless of the circumstances?		
Has anyone ever told you that they were afraid of your cat?		
Have your cat's sleeping habits changed in any way?		
Have your cat's eating habits changed in any way?		
Has your cat's ability to move around or jump on the bed changed?		
Is your cat behaving in any way that worries you or about which you would like more information?		

Comments:

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**You are taking the best care of your best friend:** Your veterinary practice is accredited by the American Animal Hospital Association. Unlike human hospitals, veterinary practices are not required to be accredited. Your veterinary team volunteered to be evaluated on about 900 standards of veterinary excellence in order to become accredited. AAHA-accredited practices are recognized among the finest in the profession and are consistently at the forefront of advanced veterinary medicine.



# Please tell us about your dog's behavior



Today's Date: \_\_\_/\_\_\_/\_\_\_ Client's Name: \_\_\_\_\_

Dog's Name: \_\_\_\_\_ Dog's date of birth: \_\_\_/\_\_\_/\_\_\_ Is this birth date estimated? known?

Dog's breed: \_\_\_\_\_ Dog's sex: M MC F FS Age at adoption: \_\_\_\_\_ weeks months years

Is your dog house trained: Yes No

	Yes	No
Do you have any worries, complaints, or problems with urination in the house now?		
Do you have any worries, complaints, or problems with defecation in the house now?		
Does your dog experience periodic bouts of diarrhea?		
Does your dog destroy anything (for example, doors, windows, sofas, shoes, or other objects)?		
Does your dog mouth anything or anyone?		
Does your dog make any sounds that worry you?		
Does your dog growl, bark, snarl, or bite?		
Does your dog pull on the lead or do other things that make it hard for you to walk with a leash?		
Have you ever worried that your dog is aggressive to people?		
Have you ever worried that your dog is aggressive to other dogs?		
Have you ever worried that your dog is aggressive to animals other than dogs?		
Has your dog ever bitten anyone, regardless of the circumstances?		
Have your dog's sleeping habits changed?		
Have your dog's eating habits changed?		
Has your dog's ability to move around or jump on the bed changed?		
Has anyone ever told you that they were afraid of your dog?		
Is your dog behaving in any way that worries you or about which you would like more information?		

Comments:

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