Patient Registration

Client Information

First Name: _____ Last Name: _____

Contact Email: _____ Phone: _____

Street Address: _____

Street Address (Line 2): _____

City/State: _____ Zip Code: _____

Secondary Contact Information

First Name: _____ Last Name: _____

Contact Email: _____ Relationship: _____

Patient Information (Your Pet)

Patient Name: _____ Last Name: _____

Weight (Est.): _____ Age/DOB: _____

Sex: _____ Neutered (Yes or No): _____

Species: _____ Breed: _____

Color: _____

Referral Information

How did you hear about us?: _____

Referring Veterinary Practice: _____

Referring Veterinarian: _____

Practice Phone Number: _____

Appointment Information

Presenting Concern/Condition: _____

Date Onset (Estimated) _____

Progression: ☐ Worsening ☐ Improving ☐ Consistent ☐ Intermittent

Has your pet been evaluated for this concern? (Yes or No) _____

Date of Evaluation (Est.): _____

Has any imaging been performed?

☐ X-Ray ☐ CT ☐ MRI ☐ Ultrasound

☐ Other ☐ None

Date of Imaging (Est.): _____

What was the diagnosis and recommended treatment plan?

_____

_____

Does your pet have any other medical concerns?

_____

_____

Is your pet CURRENTLY on any other medications?

_____

Patient Medical Records & Imaging

NOTE: Submit all patient record and imaging files to info@htown.vet