Society Hill Veterinary Hospital
501 South 2nd Street
Philadelphia, PA 19147
(215) 627-5955

Welcome

To help us provide the best experience possible, please take a few moments to complete this form. Thank you!

Registration

Owner: _____ **Date:** _____
Address: _____ **Employer:** _____
_____
Significant Other: _____ **Employer:** _____
Mobile Phone: _____ **Work Phone:** _____ **Email:** _____
Emergency Contact Name: _____ **Mobile Phone:** _____
How did you learn about our clinic? ☐ Sign Outside ☐ Website ☐ Facebook
☐ Search Engine _____ ☐ Other: _____
☐ Recommendation, and by whom? _____
Photo Consent for: ☐ Facebook ☐ SHVH Website

Preferred means of Communication:

Appointment Confirms	☐ Text Message	☐ Phone	☐ Email
Patient Reminders	☐ Text Message	☐ Post Card	☐ Email
All other medical information	☐ Text Message	☐ Phone	☐ Email

Reason for Visit: _____

Number of Pets **Dogs :**_____ **Cats:**_____ **Other (Specify):**_____

Pet Health History

Name of Pet: _____ ☐ Dog ☐ Cat ☐ Other: _____
Breed: _____ **Color:** _____ **Birthdate:** _____
Sex: ☐ Undetermined ☐ Male ☐ Neutered ☐ Female ☐ Spayed
Previous Hospital _____ **Phone** _____

Vaccination History (date and type of last vaccinations):

Canine: ☐ Rabies_____ ☐ Bordetella_____ ☐ DAPP_____ ☐ Other_____

Feline: ☐ Rabies_____ ☐ FVRCP_____ ☐ FeLV_____ ☐ Other_____

Please check (✓) any symptoms or problems that you have noticed about your pet:

- ☐ Behavioral Problems
- ☐ Bleeding Gums
- ☐ Breathing Problems
- ☐ Coughing
- ☐ Diarrhea
- ☐ Eye Discharge/Vision Change
- ☐ Gagging
- ☐ Lack of Appetite
- ☐ Limping
- ☐ Loss of Balance
- ☐ Scooting
- ☐ Scratching
- ☐ Seems Depressed
- ☐ Shaking Head
- ☐ Sneezing
- ☐ Thirst and or Urination Increased
- ☐ Vomiting
- ☐ Weakness
- ☐ Other: _____

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Pet's current medications: _____ **Current Dose:** _____
Describe your pet's diet: _____ **Feeding amount:** _____ **Frequency of meals:** _____

Additional Pet Health History

Name of Pet: _____ ☐ **Dog** ☐ **Cat** ☐ **Other:** _____
Breed: _____ **Color:** _____ **Birthdate:** _____
Sex: ☐ **Undetermined** ☐ **Male** ☐ **Neutered** ☐ **Female** ☐ **Spayed**
Previous Hospital _____ **Phone** _____

Vaccination History (date and type of last vaccinations):
Canine: ☐ Rabies_____ ☐ Bordetella_____ ☐ DAPP_____ ☐ Other_____

Feline: ☐ Rabies_____ ☐ FVRCP_____ ☐ FeLV_____ ☐ Other_____
Pet's current medications: _____ **Current Dose:** _____
Describe your pet's diet: _____ **Feeding amount:** _____ **Frequency of meals:** _____

Additional Pet Health History

Name of Pet: _____ ☐ **Dog** ☐ **Cat** ☐ **Other:** _____
Breed: _____ **Color:** _____ **Birthdate:** _____
Sex: ☐ **Undetermined** ☐ **Male** ☐ **Neutered** ☐ **Female** ☐ **Spayed**
Previous Hospital _____ **Phone** _____

Vaccination History (date and type of last vaccinations):
Canine: ☐ Rabies_____ ☐ Bordetella_____ ☐ DAPP_____ ☐ Other_____

Feline: ☐ Rabies_____ ☐ FVRCP_____ ☐ FeLV_____ ☐ Other_____
Pet's current medications: _____ **Current Dose:** _____
Describe your pet's diet: _____ **Feeding amount:** _____ **Frequency of meals:** _____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner: _____ **Date:** _____
Method of Payment: ☐ **Cash** ☐ **Check** ☐ **Mastercard** ☐ **Visa** ☐ **Other:** _____