

Welcome!

The doctors and staff of the Companion Animal Hospital of Traverse City would like to welcome you into our client family.

Our hospital was founded by Dr. Marcia A. Izo in April of 2002, a 1979 graduate of the Michigan State University college of Veterinary Medicine. Dr. Izo has served the Traverse City area since 1982.

Our hospital is committed to practicing the highest standards of veterinary medicine and being your pet's advocate. We live this commitment every day by attracting and keeping very special people on our staff. These people are highly trained and have a special caring quality that will be obvious to you and your pet(s).

We take great pride in knowing that we have taken the time to help you understand your companion's situation/condition so that you can make the right health care decisions. Our "open door" policy will help you and your companion(s) feel better even in the most difficult situations. To learn more about our practice philosophy please read The Vision at: www.cahtc.com/vision

You can make an appointment by calling us at 231-935-1511 or Toll Free at 800-319-8030. You can also contact us by e-mail at Reception@CAHTC.com.

Thank you for visiting our website. We look forward to seeing you soon.

Welcome To Our Family!

We would love to give you a tour of our facility!

Welcome

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 insure the best care possible, please take the time to fill in this form completely. Thank You!

Registration

Date _____

Owner _____ Driver's License # _____

Address _____ City _____ Zip Code _____

E-Mail Address _____

Employer _____ Work Phone _____

Home Phone _____ Home Fax _____ Cell Phone _____

Spouse _____ Last Name (if different) _____ Spouse Work Phone _____

Emergency Contact Name _____ Phone _____

How did you learn of our hospital? Yellow Pages Recommendation
 Sign Other _____

If recommended, who may we thank? _____

Number of Pets: Dogs _____ Cats _____ Other _____

Reason for Visit _____

Pet Health History

Name of Pet _____ Dog Cat Other _____

Breed _____ Color _____ Birthdate _____

Male Neutered Female Spayed

Vaccination History (Date and type of last vaccinations) _____

Please Check (✓) 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"/> Thirst and/or Urination Increased |
| <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"/> Other _____ |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Seems Depressed | |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Shaking Head | |

Pet's Current Medications _____

Describe Your Pet's Diet _____

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. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. **MUST BE 18 OR OLDER TO AUTHORIZE.**

Signature of Owner _____ Date _____

Method of Payment: Cash Check MasterCard Visa Other _____