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Chesapeake Veterinary Cardiology Associates

Welcome to CVCA

REGISTRATION

Owner _____ Date _____
 Address _____
 City _____ State _____ Zip _____
 Home phone _____ E-mail address _____
 Work _____ Cell _____ Pager _____ Occupation _____
 Spouse _____ Cell _____ Work _____ Occupation _____

I understand that payment in full is due at the time of service. I agree to assume financial responsibility for all professional fees, and agree to pay CVCA when services are rendered. I understand that a fee of \$35.00 will be incurred for all returned checks. CVCA may also recover reasonable attorney's fees and court costs incurred as a result of my failure to pay in accordance with this authorization.

Signed: _____ Date: _____

REFERRING VETERINARIAN

Name of Hospital _____ Veterinarian's Name _____
 Other Veterinarian _____

PET HEALTH HISTORY

Name of Pet _____ Dog Cat Other _____
 Breed _____ Color _____ Date of Birth _____ Male Neutered Female Spayed
 Are any surgeries or dentistry planned? Yes No If yes, when? _____ and what type of surgery _____
 Is your pet kept: Indoors Outdoors
Cats: FIV/FELV tested: Yes No If yes, when? _____ Results _____
Cats/Dogs: Heartworm tested: Yes No If yes, when? _____ Results _____ Preventative: Yes No
 Do any of your pet's relatives have heart disease? Yes No If yes, what type? _____
 Has your pet traveled to the south or western part of the country? Yes No If yes, when? _____
 What brand of food is your pet on? _____ Canned Dry

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Irregular Heart Rhythm | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Coughing / Gagging | <input type="checkbox"/> Limping/ Loss of Balance | <input type="checkbox"/> Seems Depressed |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Increased Urination/Thirst | <input type="checkbox"/> Diarrhea/ Vomiting |
| <input type="checkbox"/> Tongue Turning Blue | <input type="checkbox"/> Kidney Failure/ Liver Failure | <input type="checkbox"/> Change in Appetite/ Weight Loss |
| <input type="checkbox"/> Fainting/Collapsing | <input type="checkbox"/> Exercise Intolerance/ Weakness | <input type="checkbox"/> Food Allergies |

Please list all current medications below:

| Medication | Amount given | How often | Do you need refills? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|------------|--------------|-----------|--|
| _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Doctor use only:

History: _____ Weight: _____ BP: _____