Chesapeake Veterinary Cardiology Associates

Steven Rosenthal, DVM-ACVIM
Bonnie Lefbom, DVM-ACVIM
William Tyrrell, DVM-ACVIM
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Jennifer Sidley, DVM-ACVIM
Kristin Jacob, DVM-ACVIM
Jess Weidman, DVM-Resident

Welcome Back to CVCA

REGISTRATION

Owner_______________________________________ Date_______________

Please fill out the following gray sections if there are any changes since your last visit:

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______________________

Are any surgeries or dentistries planned? ❑ Yes ❑ No If yes, when?________and what type of surgery__________

Cats: FIV/FELV tested: ❑ Yes ❑ No If yes, when?____________Results________________________

Cats/Dogs: Heartworm tested: ❑ Yes ❑ No If yes, when?___________ Results_________ Preventative: ❑ Yes ❑ No

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

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

Please list all current medications below:

Medication	Amount given	How often	Do you need refills?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

Doctor use only:

History: Weight: BP: