



Last Name : _____ **First Name:** _____

Cell Phone: _____ **Home Phone:** _____

Street Address, City, State, Zip code:

Email: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Relationship to You: _____

Dog information

Please complete a separate form for each dog being registered.

Dog's Name: _____

Breed: _____

Sex (Please Circle): **Male / Female**

Status (Please Circle) Neutered / Spayed / Intact

(All dogs must be spayed or neutered if 8 months of age or older)

Date of Birth (If unknown, please estimate year) ____/____/____

Veterinary Clinic Name: _____

Proof of vaccinations must be presented with this form.

List any health issues or allergies:

May we give your dog treats / snacks? (Please Circle) Yes / No

List Any Behavior Issues:

Has your dog played off leash with other dogs before? _____

Has your dog ever bitten a human and drawn blood? If yes please explain.

Has your dog ever bitten another dog and drawn blood? If yes please explain.

Is there any other information that will be helpful to us in caring for your dog?

I certify that all this information is up to date and accurate.

Please circle: Yes / No

Signature: _____

Date: ____ / ____ / ____