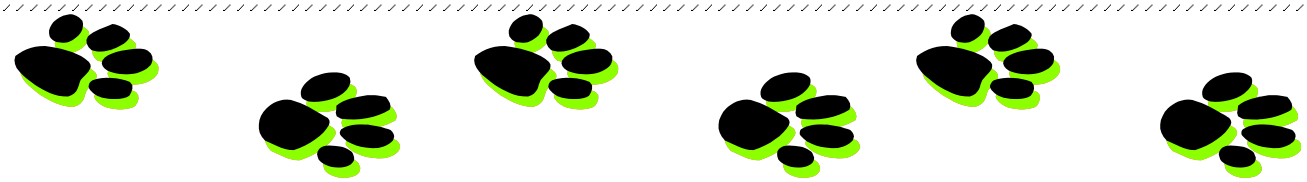

Welcome to Mount Dora Veterinary Hospital

Client Information
Today's Date: _____ Mrs.__ Mr.__ Ms.__ Dr.__ D.L.# _____
Last Name: _____ First Name: _____
Address: _____
City_____State_____Zip: _____
Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____
Preferred Contact method: _____Spouse_____
E-Mail Address: _____
How did you first hear of us? _____ Primary reason for visit: _____
Number of pets (please specify by type): _____

#1 Pet Information
Pet's Name: _____ ☐Dog ☐Cat ☐ Other_____
Sex: ☐M ☐F Age: _____ Birthday: _____ Breed: _____
Color: _____ Neutered/Spayed: ☐ Yes ☐ No At what age? _____
Any long term problems? _____
List your pet's current medications: _____

#2 Pet Information
Pet's Name: _____ ☐Dog ☐Cat ☐ Other_____
Sex: ☐M ☐F Age: _____ Birthday: _____ Breed: _____
Color: _____ Neutered/Spayed: ☐ Yes ☐ No At what age? _____
Any long term problems? _____
List your pet's current medications: _____

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 the animal. I also understand that **ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED (payment plans are not provided). I understand that payment is accepted in the form of: Cash, check, Visa, Mastercard, Discover, and CareCredit. I also understand that if I am paying with a check I will need to provide my Driver's License number.**

Signature of the client responsible for pet(s) _____ Date: _____