DELAPORTE VETERINARY HOSPITAL

Patient Drop Off Consent Form

Thank you for dropping off your pet with us today! The following information will be used to help our veterinary team accurately complete your pet's medical history for today's visit.

Today's date: ____/____/____
Your name _____ Pet Name _____

We will need to be able to contact you or someone with permission to make medical and financial decisions.
Who will we be speaking with? _____

1st Phone _____ 2nd Phone _____

Reason for visit (check all that apply)

- ☐ Vomiting
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Coughing/Sneezing
- ☐ Difficulty breathing
- ☐ Lameness or limping
- ☐ Urination issues
- ☐ Bite wound (s)
- ☐ Itching/scratching
- ☐ Hair loss
- ☐ Lethargic or depressed
- ☐ Not eating
- ☐ Losing weight
- ☐ Abnormal behavior
- ☐ Ate or swallowed something unusual
- ☐ Check a growth or tumor
- ☐ Pain
- ☐ Ears
- ☐ Other:
- ☐ _____
- ☐ _____
- _____
- _____

When did your pet last eat? _____ ☐ am ☐ pm ☐ Today *or* ☐ Yesterday
Has your pet ever had an adverse reaction to any medications? ☐ No ☐Yes
If so, describe _____

Has your pet ever had an adverse reaction to vaccines or any procedure? ☐ No ☐ Yes
If so, describe _____

Is your pet ever in pain after vaccines or other procedures? ☐ No ☐ Yes
If so, describe _____

Is your pet taking any medication(s)? ☐ No ☐ Yes
If so, describe _____

Any refills needed? ☐ No ☐ Yes _____

Please call me before treating if my fee will be over $ _____ (if left blank, we will call if fee is over $200) OR If fee will be $_____ more than the current treatment plan range.

Authorization to Provide Care

1. I am the owner (or authorized agent of the owner of) my Pet. I hereby authorize Mount Dora Veterinary Hospital, its veterinarians, technicians, and assistants to perform services, procedures, diagnostics, vaccinations, treatments, and administration of extra label medications as deemed necessary or advisable in connection with or relating to the matters described in the attached estimate or the matters that have otherwise been explained by the Mount Dora Veterinary Hospital staff. 2. I understand that there is a risk of complications with every procedure, including the possibility of death as a severe complication of surgery, anesthesia, or other procedures. I also understand that there is no guarantee as to the results of any procedures, diagnostics, vaccinations, or treatments. I understand that I may ask any questions that I have regarding any procedure, diagnostic, vaccination, or treatment recommended by the veterinarian before it is performed. 3. I understand that payment is due in full at the time services are rendered. If for any reason payment is not made at the time services are rendered or within 10 days thereafter, I understand that my account may be referred to a collection agency.

Please complete and sign below.

Signature _____ Date _____