SEMINOLE TRAIL ANIMAL HOSPITAL

Please complete the following information about you and your pet:

OWNER'S NAME _____ Spouse Name _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Cell Phone _____ Spouse Cell Phone _____ Work Phone _____

Emergency Contact/Phone _____ (relation)_____

E-Mail Address (to send reminders & newsletters only)_____

I give permission for photographs of my pet to be taken, copyrighted and used for any lawful purpose (ex. publicity, illustration, advertising, web content, etc). **YES or NO**

We will gladly prepare a written estimate if you desire. Please ask a team member or doctor.
PAYMENT IS DUE AT TIME OF SERVICES.

PET'S NAME _____ Sex _____ Spayed or Neutered: Yes or No

Age or Birth date _____ Dog/Cat/Other _____ Breed _____ Color _____

Microchipped? Yes or No Vaccinated in last 12 months? Yes or No

Name of hospital where records can be obtained _____

Is your pet currently taking heartworm preventative? Yes or No Brand _____

Does your pet have any allergies or medical problems? _____

Behavioral Concerns (chewing, house training, overly aggressive, etc.) _____

To prevent the spread of infectious diseases and parasites, hospitalized animals must be current on all vaccines and free of internal and external parasites. I authorize the doctor(s) to provide any treatment deemed necessary by the doctor(s) of Seminole Trail Animal Hospital.

Signature of owner or agent _____ **Date** _____

ACKNOWLEDGEMENT OF ABILITY TO RECEIVE WRITTEN PRESCRIPTIONS: *I, _____, UNDERSTAND MY RIGHT TO RECEIVE A WRITTEN PRESCRIPTION FOR MEDICATION THAT CAN BE FILLED AT THE PHARMACY OF MY CHOICE OR BY MY VETERINARIAN, AS PROVIDED IN S.474.224, FLORIDA STATUTES.*

_____/_____

SIGNATURE *DATE*