Pine Castle Animal Hospital New Client Form

Client Information Date:_____

First Name :_____ Last Name:_____

Owner Date of Birth: _____

Address:_____ City:_____ State:_____ Zip: _____

1st Phone Number: _____ 2nd Phone Number: _____

Email: _____

Pet Information

Name: _____ Birthday: _____ Species:_____

Breed:_____ Color: _____

Sex:_____ Neutered Y N

Medical History

Current Medications: _____

Allergies: _____

Reactions to Medications or vaccines: _____

Major Surgeries or Medical Issues: _____

Current Heart Worm Prevention:_____

Flea and Tick Prevention: _____ Microchip Number:_____

Travel History: _____

Other Things

How did you hear about us and were you referred by a friend? _____

You will be presented with a treatment plan for the cost of care before treatments are rendered.

We accept Master Card, Visa, American Express, Discover, cash, check (with valid ID), Care Credit, and Apple Pay.

Pine Castle Animal Care Center
5250 S Orange Ave Orlando FL 32809
407.855.5010

Consent for Examination, Treatment and Admission

Client's Name _____ Pet's Name _____

Species : Canine / Feline / Exotic Sex _____

The purpose of our Practice is to provide your pet with the best medical and surgical care available. The purpose of this form is to adhere to Florida Law. It sets forth the policies of Pine Castle Animal Care Center (PCACC).

I, the undersigned owner, authorized agent of the owner or Good Samaritan responsible for seeking veterinary care for the pet identified above, certify that I am over eighteen (18) years of age, and hereby consent to the examination of this pet by staff veterinarians at Pine Castle Animal Care Center.

I understand that in addition to physical examination of my pet, blood and urine tests, radiographs (X-rays) and other diagnostic tests may be necessary to determine the cause of my pet's medical condition and best course of treatment. I understand I must give my consent for each individual test that is performed, before any test can be performed, as required by Florida Law. If I have any questions or concerns about my pet's care I will discuss them thoroughly with the veterinary staff of PCACC.

I understand that the practice of medicine is not an exact science. The treatment of any patient may change dependent upon the evolving nature of the condition and the response of the patient to treatment. Complications can arise and prognoses may change. I am encouraged to discuss all questions concerning my pet's health, with my veterinarian, at all times.

I understand that vaccinations protect my pet and family from serious diseases, and also understand that vaccine administrations are not totally without risk. Vaccine reactions are rare and generally mild if they occur. They include (but are not limited to) lethargy, hives, swelling, nodule formation – tenderness - or infection at the injection site and gastrointestinal upset. I understand I should seek medical care if I suspect an adverse reaction is occurring.

If my pet is hospitalized overnight, I understand that continuous veterinary care during nighttime hours is not guaranteed. If I desire that my pet have continuous overnight care I will transfer my pet to the VEC (Veterinary Emergency Clinic of Central Florida), or other facility, where continuous veterinary supervision is available.

I understand that an estimate of the costs for veterinary services will be provided to me upon my request and that I am encouraged to discuss all fees attendant during the ongoing care of my pet. I agree to assume full financial responsibility and pay for the balance of all services rendered at the time of patient discharge. I agree to pay a fee of $35.00 for any check returned for insufficient funds and a monthly processing fee of $25.00 should a billing statement need be generated.

If my address or phone number(s) change or a change of patient ownership occurs I will notify PCACC of such change continuous communications concerning this patient's health can be maintained.

I acknowledge that no guarantee of successful treatment has been made to me. I hereby release and discharge PCACC, its doctors and staff, from all claims and demands I have or may have against PCACC, its doctors and staff, by reason of any medical, surgical, diagnostic procedure, deficiency thereof, adverse drug reaction or performance of other services as they relate to this patient.

I hereby state I have read and understand this agreement, and that I am in agreement with the policies set forth. This agreement will be binding for the duration I own this patient.

_____ _____
Signature of Owner or Authorized Agent Date

_____ _____
Witness Date

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Orlando, Florida 32809
407-855-5010

Text Message and E-mail consent:

Pine Castle Animal Care Center would like to offer you the ability to receive text message and e-mail reminders for any of your appointments booked, your vaccines, and any exams, rechecks, or testing recommended by the Doctor. In the near future, we are also planning to send other health information out by SMS text or e-mail such as letting you know that your results are back, or that we need to get in touch with you. We might also occasionally send information about healthcare for your pet or any specials we may be having that you might be interested in.

We do please ask that for any changes or questions about your appointment or your pet(s), please call the clinic directly and we would be happy to help you. We do hope these changes will make things easier. Messages are generated by Vetboost, a secure service. The practice will never sell your information.

Please fill out the following information:

Client Name:_____

Mobile number:_____

E-mail:_____

Signature:_____

Today's date:_____

I CONSENT to the practice contacting me by:

Text message ☐ E-mail ☐

I will ensure that I keep the practice informed of my up to date mobile number and e-mail at all times, or if the number is no longer in my possession.

I DECLINE to the practice contacting me by SMS text and e-mail:

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