UNDERHILL ANIMAL HOSPITAL

4900 Lake Underhill Rd, Orlando Fl 32807 (407)277-0927

Out Patient Drop-Off Form

Client Name
Address

Telephone

Name
Breed & Sex
Weight
Age

_____ **is being dropped off for the following reason:** *(PLEASE NOTE: We require an examination with vaccines)*

☐ **Annual Wellness Exam** ☐ **Illness or Inury (Please Explain):** ☐ **Other (Please Explain):**

_____

_____

_____

For today's visit, has _____ shown any of the following symptoms? *(Check all that apply)*

☐ Changes in activity level
☐ Coughing/ Sneezing/ Gagging
☐ Excessive panting
☐ Stiffness or Pain
☐ Limping
☐ Itching/ Scratching
☐ Hair Loss
☐ Scooting
☐ Vomiting
☐ Diarrhea or Constipation
☐ Changes in appetite- Increased or Decreased?
☐ Changes in urination- Increased or Decreased?
☐ Changes in thirst- Increased or Decreased?
☐ Check a growth or tumor- Please note location below:

Is there any other information you would like to add? _____

_____

_____

Please list current medications, INCLUDING heartworm and flea prevention:

_____

_____

*** Do you consent to **Life Saving Emergency Care (CPR)** should the need arise? ☐ Yes ☐ No

*** After examination, may we proceed with tests and/or treatment? ☐ Yes ☐ No ☐ Call First

PLEASE NOTE:

- It is required that **any pet** admitted into Underhill Animal Hospital be **free of fleas and ticks. If fleas or ticks are found, your pet will be treated at your expense.**
- **Aggressive** animals that required special handling ***may incur an additional charge.***
- Underhill Animal Hospital will **NOT** be responsible for personal items left with pets. **PLEASE TAKE ALL LEASHES, COLLARS, ETC. WITH YOU WHEN YOU LEAVE.**

Authorization to Provide Care

I am the owner or responsible agent of the above named animal and hereby authorize performance of procedures as marked above. I understand that any quotes or estimates given for services to be performed are ***ONLY ESTIMATES***, and I take full responsibility for payment of charges. Payment is due when services are rendered. It is also understood that if I do not pay this account as agreed that past due accounts may be referred to a collection agency.

Signature_____ Date _____

Contact Phone Number _____ Secondary Phone Number _____

ALL DROP OFF PATIENTS WILL BE READY FOR PICK UP
MON- FRI BETWEEN 4:00-7:00 PM SAT BETWEEN 2:30-4:00 PM