Hiawassee & Clarcona Ocoee Pet Hospital 7045 Clarcona Ocoee Rd Orlando, FL 32818

Client/Patient Registration
Please Print Legible

Owner's Name(s): _____ **Date:** _____

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

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email Address: _____

Emergency Contact(s): _____ **Phone:** _____

#1 Pet's Name: _____ **Canine** ___**Feline** ___ **Other:** ____ **Breed:** _____

Color: _____ **Birthdate:** _____ **Male Neutered** _____ **Female Spayed** _____

Is your pet up to date on their vaccines? Yes ____**No**____ **Known allergies?** _____ **Current medications?** _____

What is your pet's reason for visiting us today? _____

Please check any symptoms that you have noticed about your pet:

	Vomiting/ Diarrhea		Lethargic		Sneezing		Scooting		Nail Trim
	Scratching		Increased Urine/Thirst		Limping		Smelly Ears		Vaccines
	Loss of Appetite		Increased Thirst		Coughing/ Gagging		Eye Irritation		Other

#2 Pet's Name: _____ **Canine** ___**Feline** ___ **Other:** _____ **Breed:** _____

Color: _____ **Birthdate:** _____ **Male Neutered** _____ **Female Spayed** _____

Is your pet up to date on their vaccines? Yes ____**No**____ **Known allergies?** _____ **Current medications?** _____

What is your pet's reason for visiting us today? _____

Please check any symptoms that you have noticed about your pet:

	Vomiting/ Diarrhea		Lethargic		Sneezing		Scooting		Nail Trim
	Scratching		Increased Urine/Thirst		Limping		Smelly Ears		Vaccines
	Loss of Appetite		Increased Thirst		Coughing/ Gagging		Eye Irritation		Other

How did you hear of us?

Google		Friend/Family	
Facebook		Clinic Sign/Drive By	
Internet			

I hereby authorized the veterinarians & staff to examine, prescribe for, and/or treat the above-described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that any and all charges will be paid for at the time when services are rendered and that a deposit may be required for hospitalization, surgery and/or other routine services and treatment.

☐ By checking this box, I give HCO Pet Hospital written permission to share my pet's medical information and records, including but not limited to, Medical Records with Diagnosis, Lab work, X-rays, and vaccination records to Groomers, family members, and other veterinarians participating in the care of my pet.

☐ By checking this box, I give HCO Pet Hospital permission to use my pet's name and picture on their website as well as in other marketing materials.

Signature of Owner: _____ **Date:** _____