

# Wellness Registration

Owner's Name: Ms. Mrs. Mr. First: \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #'s: Home \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_ Number if needed today \_\_\_\_\_

Have you used this clinic before?  Yes  No If yes, when? \_\_\_\_\_

## Pet Health History

Pet's name \_\_\_\_\_  Dog  Cat  Other

Breed: \_\_\_\_\_ Color(s) \_\_\_\_\_

Age/Birthdate \_\_\_\_\_ Sex: **F SF M NM**

Vaccination History (date and type of last vaccinations) \_\_\_\_\_

Is your pet on heartworm preventive?  Yes  No Brand name of preventive: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Please check all the symptoms below that apply to your pet:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Behavior problems  | <input type="checkbox"/> Eyes bulging     | <input type="checkbox"/> Scooting        | <input type="checkbox"/> Weakness                   |
| <input type="checkbox"/> Bleeding gums      | <input type="checkbox"/> Gagging          | <input type="checkbox"/> Scratching      | <input type="checkbox"/> Thirst/urination increased |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Seems depressed | <input type="checkbox"/> Vomiting                   |
| <input type="checkbox"/> Coughing           | <input type="checkbox"/> Limping          | <input type="checkbox"/> Shaking head    |   |
| <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Loss of balance  | <input type="checkbox"/> Sneezing        | <input type="checkbox"/> Other _____                |

Current medications: \_\_\_\_\_ Current diet: \_\_\_\_\_

## Authorization – Consent and waiver

I hereby declare under penalty of perjury, that I am the owner of, or I am authorized to, present the above named animal for listed services. I understand administration of anesthesia and surgery present risk to any animal, however, may be greater to older animals, and a complete examination by a veterinarian is recommended prior to surgery. I request the SPCA of Central Florida (SPCA) perform services on my animal. I agree to indemnify and hold harmless, the SPCA and its elected officials and employees, in the event of illness, injury or death to my animal arising out of the listed services provided hereto. The SPCA is in no way responsible for any injury or loss due to transportation of animals to or from the SPCA facility or on the immediate premises. I recognize the SPCA will not perform heartworm tests, feline leukemia test, immunodeficiency tests, or any other tests or examinations unless requested. I give permission to perform other services, at an additional cost, if medically, immediately required. I understand I am required to pay all boarding fees for leaving my animal beyond scheduled pick up date and time, and, if I do not pick up my animal within ten (10) days of the scheduled pick up date, it will be deemed to be abandoned and the SPCA may dispose of said animal by adoption or euthanization.

**I ASSUME RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF THIS ANIMAL. I UNDERSTAND A SURGERY DEPOSIT MAY BE REQUIRED AND ALL OTHER CHARGES WILL BE PAID AT THE TIME OF RELEASE.**

Owner's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Payment method:  Cash  Check  MasterCard  Visa  Discover  Debit