CORAL BREEZE ANIMAL HOSPITAL
DROP-OFF FORM

8893 S Military Trail, Boynton Beach, Fl 33436
Christopher Carmona, DVM & Maite Cintrón, DVM

Your Name: ______________________________

Number(s) where we can reach you at today: ___________________________________
Time we can reach you at this number: _______________

Are you the: O Owner O Son / Daughter O Friend O Legal Guardian O Other: ___________________

Patient Name ___________________________ **Reason for today's drop off?**
____
____
____

Please check all of the symptoms that your pet has:

O Straining to urinate O Increase in water intake O Watery eyes O Shaking Head
O Frequent urination O Decrease in water intake O Depressed O Lethargic
O Constipated O Increase in appetite O Scratching O Weakness
O Diarrhea O Decrease in appetite O Coughing O Restless
O Vomiting O Weight loss O Panting O Seizures
O Limping O Weight gain O Odor O Hair loss
O Pain (where?)
____
O Growths (where?)
____
O Change in behavior (describe)
____
How long has your pet had these symptoms?___________________________

Is your pet on heartworm prevention? Yes O No O What kind? ______________________
Is your pet on flea prevention? Yes O No O What kind? ______________________
Is your pet strictly indoor O outdoor O both indoor/outdoor O
Is your pet on any medication(s)? Yes O No O
If yes, what medication(s) (dosage and times a day) and why?
____
What do you feed your pet and how much? ____

The Veterinarian will perform a thorough physical exam as soon as the schedule allows. A technician or Doctor will contact you as soon as possible with a plan or to schedule a discharge time.

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I am the owner or agent for the owner of the animal(s) described on this form and have the authority to execute this consent.

I request that the veterinarians, agents and employees of Coral Breeze Animal Hospital perform the services which are necessary to the examination, medication and treatment of the animals specifically described and identified on this form.

I authorize the veterinarians on duty (and the assistants they designate) to examine the animal(s) and to administer medical treatment or emergency surgical treatment which is considered therapeutically and/or diagnostically necessary on the basis of the findings during the course of the examination. Therefore, I hereby consent to and authorize the performance of such procedure(s) as are necessary and desirable in the exercise of the veterinarian's professional judgment.

If my pet should injure itself in an escape attempt, refuse food, soil itself, become ill or die while in the hospital, I will hold Coral Breeze Animal Hospital, and staff free of any responsibility and/or liability in the absence of gross negligence.

If I neglect to pick up my pet within five days of written notice that it is ready for release, it may be assumed that the pet is abandoned. Coral Breeze Animal Hospital and its agents are authorized to dispose of it as they see fit. Abandonment does not release me of my obligation to pay the bill.

I further understand that if my pet is found to be infected with either external or internal parasites, it will be treated for these at my expense.

I understand that the treatment of the patient will be conducted with due care and in accordance with the prevailing standards of competency in Veterinary Medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by the veterinarians, agent or employees of Coral Breeze Animal Hospital.

I assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon discharge. In case of non-payment, I am aware that Coral Breeze Animal Hospital will charge the cost of collecting the debt on the amount owed for services. This includes the collections company's charges, attorney's fees and interest of 1.5 % per month (18% annum).

I understand that a written estimate of charges is available within reasonable time at my request. I also consent to the release of medical information.

Patient name: ________________________

Procedures to be performed: ____

Estimated costs of procedure: __________________

A technician or Doctor will call if additional diagnostics and/or treatments are needed, or if the bill will be greater than the estimate.

Signature _____________________________ **Date** ___________________________

Phone number(s) we can reach you at today: _________________________________

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