



**LAKE NONA ANIMAL CLINIC**  
**10743 NARCOOSSEE RD. STE. A-22**  
**ORLANDO, FL 32832**  
**(407) 249-4100**

**WELCOME**

Thank you for giving us the opportunity to take care of your beloved pet(s). So that we may serve you better, please complete the following information.

**OWNER INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Driver's License # \_\_\_\_\_

.....  
**CO-OWNER INFORMATION**

Co-Owner: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Driver's License# \_\_\_\_\_

.....  
**How did you hear about us?** Drove by \_\_\_\_ Internet \_\_\_\_ Mail \_\_\_\_ Other \_\_\_\_  
Personal Referral (Whom may we thank?) \_\_\_\_\_

**I certify that all the information that I have provided is correct.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

For Office Use Only:

\_\_\_\_ Verified ID

\_\_\_\_ Information has been updated on the computer. \_\_\_\_ E-mail

\_\_\_\_ Previous Med Hx checked and Reminders updated.

\_\_\_\_ Scanned.



**Lake Nona Animal Clinic Policies:**  
Please initial by each statement and sign at the bottom.

\_\_\_\_ **ALL PAYMENTS ARE DUE AT THE TIME OF SERVICES RENDERED. We accept Cash, all major credit cards & care credit.**

\_\_\_\_ **Any balances carried at Lake Nona Animal Clinic will be charged a monthly service fee on all accounts over 30 days equal to the greater of a minimum charge of \$3.00 or 1.50% per month.**

\_\_\_\_ **Balances on accounts over 90 days will be submitted to collections and an additional \$10 processing fee will be added to the balance due.**

\_\_\_\_ **All prescriptions dispensed are non-returnable and non-refundable. By law, we are not permitted to accept back any prescriptions that have left our facility. This includes heartworm prevention and flea and tick products.**

\_\_\_\_ **Please allow 24 hours for prescription refill requests to be ready.**

**We will not sell or share any personal information unless required by law.**

\_\_\_\_ **The record will be under the primary owner. Any changes to the information on the account need to be approved by the primary owner. Any changes to the primary owner's name need to be approved and documented. Identification might be required.**

\_\_\_\_ **Medical records will not be shared unless approved by the primary owner. Please allow 48-72 hours for full records to be ready once requested. Vaccine information can be faxed and e-mailed to boarding and grooming facilities at your request. Allow 2-6 hours for completion. For faster turnaround please make these requests yourself.**

\_\_\_\_ **We love our patients and taking pictures with them. Please let us know if you consent to us using your pet (s) 's pictures on our website and social media pages. Circle one: YES NO**

**I have read and understand the above statement and agree to all terms therein.**

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**PET INFORMATION**

**Pet's Name** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

**Specie:** Dog \_\_\_\_\_ Cat \_\_\_\_\_ Other \_\_\_\_\_

**Breed** \_\_\_\_\_ **Color/ Marking** \_\_\_\_\_

**Sex:** Female \_\_\_ Male \_\_\_ **Spayed / Neutered** \_\_\_\_\_ **Last Vaccines Date** \_\_\_\_\_

**Current Medications** \_\_\_\_\_

**Medical Condition** \_\_\_\_\_

**Allergies Known** \_\_\_\_\_



**Pet's Name** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

**Specie:** Dog \_\_\_\_\_ Cat \_\_\_\_\_ Other \_\_\_\_\_

**Breed** \_\_\_\_\_ **Color/ Marking** \_\_\_\_\_

**Sex:** Female \_\_\_ Male \_\_\_ **Spayed / Neutered** \_\_\_\_\_ **Last Vaccines Date** \_\_\_\_\_

**Current Medications** \_\_\_\_\_

**Medical Condition** \_\_\_\_\_

**Allergies Known** \_\_\_\_\_



**Pet's Name** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

**Specie:** Dog \_\_\_\_\_ Cat \_\_\_\_\_ Other \_\_\_\_\_

**Breed** \_\_\_\_\_ **Color/ Marking** \_\_\_\_\_

**Sex:** Female \_\_\_ Male \_\_\_ **Spayed / Neutered** \_\_\_\_\_ **Last Vaccines Date** \_\_\_\_\_

**Current Medications** \_\_\_\_\_

**Medical Condition** \_\_\_\_\_

**Allergies Known** \_\_\_\_\_

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