

Animal Eye Associates, P.A.
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Maitland, Florida 32751
(407)629-0044 ext. 1

Welcome to Animal Eye Associates. So we may become more familiar with you and your pet, please fill out the following form.

STANDARD CONSENT & CLIENT INFORMATION

OWNER'S NAME: _____

SPOUSE/OTHER: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: () _____

CELL PHONE: _____

OWNER'S EMPLOYER: _____ PHONE: () _____

SPOUSE'S EMPLOYER: _____ PHONE: () _____

REFERRING VETERINARIAN: _____ CLINIC NAME: _____

ANIMAL INFORMATION

PET NAME: _____ DOG () CAT () OTHER: () BREED: _____

DATE OF BIRTH: _____ COLOR: _____ SEX: _____ ALTERED _____

CURRENT MEDICATIONS: _____

HAS YOUR PET HAD A SEIZURE BEFORE? _____ WHEN: _____

PLEASE LIST ANY MEDICAL CONDITIONS OR ALLERGIES/REACTIONS:

**PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED
THERE IS NO BILLING SERVICE**

FORM OF PAYMENT DESIRED

CASH (___) CHECK (___) VISA (___) MASTERCARD (___) DISCOVER(___)

I am the owner of the above pet, or am acting as an agent for the owner, and accept full financial responsibility. I give permission to proceed for any medical/or surgical therapy as needed as discussed and agreed upon with the doctor.

DRIVER'S LICENSE NUMBER: _____

SS#: _____

DATE: _____ **SIGNATURE:** _____