Surgical/Dental Released Form

Trinity Oaks Pet Wellness Center
10003 Trinity Boulevard
Trinity, FL 34655
Telephone: (727) 375-2882
info@trinityoakspwc.com

Patient Name: _____
Owner: _____

Surgical/Dental Procedure

All Animals entering the hospital must be up to date on vaccinations and required Laboratory test. All animals must be freed to external/internal parasites. Vaccinations, Required laboratory tests, and/or treatment for external/internal parasites will be at client's expense.

Vaccinations Due: _____

Laboratory Tests Required: _____

MICROCHIPING (home again) YES _____ NO_____ (Cost is $65)

I certify that I own the described patient and do hereby consent and authorize Trinity Oaks Pet Wellness Center and it's staff to hospitalize my pet; to administer Vaccination, medications, and anesthesia; and to perform tests, surgical procedures or treatments that the doctor deems necessary for the safety, well being of my pet while under it's care.

In the event that emergency treatment is required and I cannot be reached, I authorize Trinity Oaks Pet Wellness Center to perform medical and/or surgical treatment necessary to preserve the life of the patient until I can be contacted for further authorization.

I accept financial responsibility for the services provided. I further understand that payment in full is due upon the release of the patient from the hospital or upon termination of services.

I hereby certify that I have read and fully understand the authorization for medical and/or surgical treatment and I understand the reason for and the risks involved with the medical or surgical treatment and I have discussed any questions with the doctor.

SIGNATURE: _____ DATE: _____

CONTACT PHONE # _____