

Patient Drop-Off Form

Patient: _____ Date: ___/___/___

Client: _____

What is/are the primary reason(s) your pet is being seen today?

When did you first notice the problem? _____

Has your pet had this problem before? If so, when? _____

When was the last time your pet ate? _____ Drank water? _____

When did your pet last urinate? _____ Defecate? _____

Have you observed any coughing, sneezing, vomiting or diarrhea (if not noted above)? Please briefly explain/describe:

If your pet is on any medication(s), please complete the following:

Name: _____ Last given: _____

Name: _____ Last given: _____

Name: _____ Last given: _____

Name: _____ Last given: _____

If your pet is on flea preventative, please complete below (we reserve the right to treat for fleas if necessary):

Name: _____ Last given: _____

Please initial:

Please consult me before beginning treatments and/or testing _____

Please begin treatments and/or testing as deemed necessary _____

Payment is due at time of service. We will do our best to provide an estimate of costs and attempt to reach you before completing any treatments. In the event of emergency, we will perform necessary life-saving procedures within reason and to the best of our ability while your pet is in our care unless you decline (please request a DNR form if you do not wish for these procedures to be performed).

X _____

Owner Signature

_____/_____/_____
Date

Contact phone number _____