



Patient Drop Off and Treatment Authorization Form

Your Name _____ Your Pet's Name _____

HOW CAN WE HELP YOUR PET TODAY _____

Best Contact Phone Number: _____

Appetite: **Normal** **Decreased** **Increased**

What do you feed your pet: _____ When did your pet last eat _____

Has your pet eaten anything unusual (Table scraps, trash, etc) _____ if so what: _____

Drinking: **Normal** **Decreased** **Increased**

Is your pet experiencing any ...

Vomiting _____ if yes...How often? _____ For How long? _____

Diarrhea _____ if yes...How often? _____ For How long? _____

Sneezing _____ if yes...How often? _____ For How long? _____

Coughing _____ if yes...How often? _____ For How long? _____

Limping _____ Which Leg(s) _____ For how long? _____

Is your pet _____ Inside only _____ Outside only _____ Both

Please list any medications / vitamins / supplements your pet is taking. **(This includes heartworm and flea prevention)** _____

Is your pet exposed to any other animals? _____

Has your residence recently been treated (pesticides, carpet cleaner, etc)? _____

Are there any other problems that you would like the doctor to address today? _____

PLEASE CHECK ONE OF THE OPTIONS BELOW

I give my permission for the above listed pet to receive treatment as needed not to exceed
_____ 200.00 _____ 400.00 _____ 600.00 _____ Treat as needed

OR

_____ Please do not perform ANY treatment on my pet until I (or my representative) can be contacted.

Please note that our hospital is FLEA Free. If fleas are found on your pet, treatment will be performed at your expense. I have read and understand all of the above policies.

Financially Responsible Person: _____
Signature Date

Technician Notes _____

Technician Initialed _____