



Drop-Off Authorization

Patient's Name: _____ **Date:** _____

Who are we contacting today: _____ Phone Number: _____

Please read and sign the authorization on the back of this form.

We have arranged for you to leave your pet here for the doctor to perform an examination. Please read through the following questions and **answer as thoroughly as possible.**

Do you have Pet Insurance? Yes No

If yes, what company? _____

If this is a new concern, please describe concerns in detail. **If this is a recheck, please detail how patient has been doing since initial visit:**

Diet: _____ How much: _____ How often: _____

Treats/Table Food: _____

Is your pet on flea/tick prevention? Yes No

If yes, what brand? _____

Is your pet on heartworm prevention? Yes No

If yes, what brand? _____

What type of at home dental care is your pet currently receiving? _____

CATS ONLY: Indoor Only Indoor/Outdoor Outdoor Only

What medication(s) and/or supplement(s) has your pet received in the last 24 hours?

Name of Medication:	Amount Given:	What Time:

Is your pet lethargic? Yes No Unknown

Pet's water intake has: decreased increased unchanged unknown

Pet's appetite has: decreased increased unchanged unknown

Is your pet vomiting? Yes No Unknown

If yes, what color? _____ What substance? _____

When did vomiting start? _____ How often? _____

Is your pet having diarrhea? Yes No Unknown

If yes, what color? _____ What substance? _____

When did diarrhea start? _____ How often? _____

Has your pet had access to foods other than its normal pet food? Yes No Unknown

If yes, please specify: _____

Has your pet had any access to toxins (i.e., gum, grapes), plants, human medication, etc.? Yes No Unknown

If yes, please specify: _____

Is your pet sensitive or allergic to any medications or food? Yes No Unknown

If yes, please specify: _____

Is your pet coughing and/or gagging? Yes No

If yes, is there anything being produced? Yes No

If yes, please describe material: _____

Is your pet sneezing or having eye/nasal discharge? Yes No

If yes, please describe: _____

Is your pet lame, sore, and/or injured? Yes No

If yes, please specify where: _____

If yes, how long have you noticed symptoms: _____

Since symptoms started, they have: worsened remained the same improved

I am the owner/agent for the described animal. I request and authorize an exam for my pet along with any approved diagnostics and treatments. If recommended for my pet, I understand and accept that when anesthesia and/or sedation is involved there are always inherent risks, including death. I understand payment is due when my pet is discharged. I accept financial responsibility for charges incurred for this pet.

Signature: _____ Date: _____