Companion Animal Hospital

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# PATIENT DROP OFF AND CONSENT FORM

Client Name: _____ Pet's Name: _____

- What are we seeing your pet for today? _____
- What food do you feed your pet? _____
- How much do you feed? _____
- Any change in **food** or **water** intake? ___ Increased ___ Decreased ___ No change
- Any change in your pet's **urination** or **defecation**? __ Yes __ No. If yes, what changes have you noted and when did you first notice? _____
  _____
- Any change in your pet's activity level? _____
- Have you noticed any __ **Coughing** ___ **Sneezing** ___ **Vomiting** or ___ **Diarrhea**?

  If yes, please explain and note when you first observed symptoms: _____
  _____
- Any **lumps** or **bumps** noted? _____ If yes, please describe location and how long it has been present:
  _____
  _____
- Is your pet **sensitive** or **allergic** to any medications/food/vaccines? ___ Yes __ No

  If yes, please explain: _____
  _____
- Does your pet receive any **dental care** at home? (Brush teeth, Greenies, water additives, etc.)
  _____
- What **medications** or **supplements** does your pet receive? (Including heartworm prevention & flea/tick prevention): _____
  _____
- If presenting for **surgery** or a **dental**, was your pet fasted overnight and this morning?
  ____ Yes ____ No
- Please indicate whether you would like us to:
  _____ Call when examination is complete for a treatment estimate –OR-
  _____ Treat as necessary
- Please note, we will strive to keep charges in line with any estimate given, however, unforeseen situations may arise at which time we will inform you of additional charges. If we cannot reach you, and a procedure needs to be performed, it will be done and charges will appear on your bill.

  **Initials: _____**

- All patients admitted to the hospital are required to be current on all vaccinations; all pets must be free of external parasites. Animals with fleas or ticks will be administered a preventative at the owner's expense. **Initials: _____**

Procedures to be performed: _____
_____
_____
_____

Medications that need to be refilled and quantity you are requesting. _____
_____
_____
_____

## Charges for all services must be paid in full at time of discharge.

Client Signature: _____ Date: _____

Contact Number: _____ Alternate Number: _____