



FOUR PAWS & HOOVES

— Veterinary Clinic —

DROP OFF FORM

CONTACT INFORMATION

Name: _____ Date: _____

Pet's Name: _____ Phone number where I can be reached today: _____

MEDICATIONS

Did your pet eat this morning?: Yes No Regular diet or other?: _____

Pet's Current Medications: _____

If yes, please list: _____

Is your pet allergic to any medications or vaccinations?: Yes No

If yes, please list: _____

DIET

Did your pet eat this morning?: Yes No Regular diet or other?: _____

Appetite?: Normal Increased Decreased Other: _____

Does your pet get table scraps?: Yes No Food allergies: _____

REASON FOR VISIT

My pet is here for: Routine Services Bloodwork _____ X-Rays

My pet is here for a recheck of: _____

My pet is sick: (please complete the following)

My main concern is: _____

Has your pet been treated before for the same complaint?: Yes No

Length of illness or changes in pre-existing condition: _____

Please check any symptoms or problems you have noticed about your pet:

- | | | |
|---|--|---|
| <input type="checkbox"/> Behavior Changes | <input type="checkbox"/> Discharges - Explain: _____ | <input type="checkbox"/> Shaking Head |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Limping - Which leg? _____ | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Urination Increase |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Lump - Where? _____ | <input type="checkbox"/> Urination Decrease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Scooting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Gagging | Other: _____ | |

VACCINATIONS

| | |
|---------------|--|
| CANINE | <input type="checkbox"/> All Needed <input type="checkbox"/> All Current <input type="checkbox"/> Distemper/Parvo <input type="checkbox"/> Bordetella <input type="checkbox"/> Rabies <input type="checkbox"/> Heartworm Test <input type="checkbox"/> Parasite Check Is your dog on monthly heartworm prevention? <input type="checkbox"/> Yes <input type="checkbox"/> No Rx Name: _____ Flea/Tick Prevention? <input type="checkbox"/> Yes <input type="checkbox"/> No Product Name: _____ |
| FELINE | <input type="checkbox"/> All Needed <input type="checkbox"/> All Current <input type="checkbox"/> FVRCP <input type="checkbox"/> Leukemia <input type="checkbox"/> Rabies <input type="checkbox"/> FIV/FELV Test <input type="checkbox"/> Parasite Check Is your cat on monthly heartworm prevention? <input type="checkbox"/> Yes <input type="checkbox"/> No Rx Name: _____ Flea/Tick Prevention? <input type="checkbox"/> Yes <input type="checkbox"/> No Product Name: _____ |

AUTHORIZATIONS

To promote the diagnosis of your pet, please authorize or decline the following:

- | | | | |
|--|------------------------------|-----------------------------|--------------------------------------|
| Authorization of Bloodwork if needed: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Call Before |
| Authorization of X-Rays if needed: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Call Before |
| Authorization of Ear Smear if needed: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Call Before |
| Authorization of Urinalysis if needed: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Call Before |
| Authorization of Medication if needed: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Call Before |

STATEMENT OF OWNERSHIP AND CONSENT: I am the owner and/or agent of the above animal and I authorize Four Paws & Hooves Veterinary Clinic staff to provide care and perform any treatment, including the administration of anesthesia and surgical procedures they consider reasonable and necessary for my animal, and I consent to such services. I understand that with any medical or surgical procedures there are always risks involved, including death, and that no warranty or guarantee is being made as to the results or cure. I agree that additional charges will accrue if my animal is not picked up on the day he or she is ready to be released from the clinic. **I will be responsible for all charges incurred.** If I neglect to contact/pick up my pet(s) within 7 days of the pick-up date, Four Paws & Hooves Veterinary Clinic may assume my pet has been abandoned and is hereby authorized to dispose of the pet(s) as it deems best (including euthanasia). I understand that all veterinary services are to be paid for at the time of such services are provided. All unpaid checks and delinquent accounts will be transferred to a collection agency.

Owner/Authorized Caregiver Signature: _____ Date: _____

Additional phone number to be reached at: _____

Items left with pet (leash, blanket, etc.): _____