PET Appointment or Drop-Off Information/Release

Date: **<date>**	Patient: **<Animal>**		Client: **<first-name> <last-name>**		
Email:	**<e-mail>**				
Home Phone:	**<area> <phone>**	Business:	**<business>**	Cell:	**<cell-phone>**

Add'l Phone: _____

Reason for today's visit or drop off:_____

Illness/problems please check all symptoms that apply to your pet.

( ) Vomiting ( ) Lethargic ( ) Sneezing ( ) Appetite Increase ( ) Constipation ( ) Shaking Head
( ) Diarrhea ( ) Depressed ( ) Panting ( ) Appetite Decrease ( ) Scooting on Rear ( ) Scratching Skin
( ) Weight Loss ( ) Gagging ( ) Difficulty Breathing ( ) Increase Water Intake ( ) Blood in Urine ( ) Hair Loss
( ) Weight Gain ( ) Coughing ( ) Restless ( ) Decrease Water Intake ( ) Frequent Urination ( ) Watery Eyes
( ) Seizures ( ) Odor ( ) Weakness ( ) Straining to Urinate
( ) Pain: where:_____ ( ) Limping: where:_____
( ) Bleeding: where:_____ ( ) Discharge: where & color:_____
Describe in further detail any symptoms marked above, include location: _____
How long has your pet had these symptoms? _____

What brand of food & how much do you feed your pet? _____
Do you feed can or dry, or both? _____ When was the last time your pet ate? _____
Do you give your pet any treats or supplements? List _____
Is your pet on any medications? List _____
****Feline Patients:** Is your cat: ( ) Indoor ( ) Outdoor

DROP OFF POLICIES

Vaccinations: Pet must be current on vaccinations. If not current, we will vaccinate and charge for the service unless the pet has an illness that prevents your pet from being vaccinated today.

Flea's presence: To keep all pets free of fleas in our office and exercise yard, your pet must be free of fleas. All pets will be examined and if fleas found, will be administered flea control and charged to you. All pets must be given flea control within the last four weeks. When was your pet's last application? _____

Does your pet need any additional care while here? Circle any work you desire. Nail Trim Anal Glands Expressed
Ear Care Medications/Refills Microchip Furminator Other _____

Do you wish for an estimate to be made before services are rendered? *(Cost does not include medication and treatment.)*
Yes ( ) I wish for an estimate to be made before services are rendered.
No ( ) I authorize exam and diagnostic services up to $400.00 without an estimate.

In case of an emergency for your pet and we cannot reach you, then we will do whatever is necessary to stabilize your pet. I understand in the event of an emergency, and you cannot reach me, I authorize you to stabilize my pet and I am responsible for the charges.

If a medical problem arises during my pets stay, I authorize the doctor to treat my pet. **Yes( ) No( )**

Sedative Release Authorization: Creedmoor Road Animal Hospital will use all reasonable precaution against injury, escape, or death of my pet. I understand all sedation involves some risk to my pet. I acknowledge that no guarantee has been made as to the results that may be obtained, and understand that there may be risks involved with sedation and complications, including death, may arise. I will not hold Creedmoor Road Animal Hospital, or their doctors, or the staff, liable for any complications or unforeseen results. I authorize sedation if necessary.

_____ **Pick-Up Times:** Pick-up times for drop-offs usually fall between 4:00pm-6:00pm, unless otherwise requested.

Signature of owner or Authorized Agent _____ Date _____

_____ (please initial) All products and services must be paid in full upon completion