Date: _____ Client: _____ Patient: _____

# Drop-Off History and Consent Form

**Vaccines** current (circle all that apply): Rabies Felv/DDRC/Distemper/Parvo Kennel Cough Other?_____

**Vomiting** (if yes, describe and give length of time): Yes/No _____

**Diarrhea** (if yes, describe and give length of time): Yes/No _____

**Eating**: Normal/decrease/increased/not eating How long has there been a change? _____

**Drinking**: Normal/decrease/increased/not drinking How long has there been a change? _____

**Urinating**: Normal/decrease/increased/not urinating How long has there been a change? _____

Changes in behavior (describe; i.e. more tired, hiding more, lameness, etc): _____

On any medications or supplements (including over-the-counter medications): _____

Which medication/supplements did your pet get today? When?: _____

Any illness/condition diagnosed at another veterinarian (i.e. diabetes, allergies, Addison's, etc): _____

| **Possible Additional Costs**: After an initial examination, we may recommend bloodwork, radiographs or other treatments or procedures. **PLEASE CHOOSE ONLY ONE OPTION** | |
|---|---|
| [ ] | Perform any diagnostics or procedures that the Doctor feels necessary. I agree to assume financial responsibility for these charges. |
| [ ] | Call me after the physical exam and provide an estimate of any additional procedures. I understand that if I cannot be contacted at this number, necessary radiographs, bloodwork, or other diagnostic and or minor treatment procedures will be performed. I agree to assume financial responsibility for these additional charges. Major surgeries or medical procedures will not be performed until we are able to contact you. |
| [ ] | Recommended tests up to $_____ then call (indicate maximum dollar amount you are willing to pay for recommended test before you wish to be called. This amount is for diagnostics only, not treatment. You will be called to discuss result of tests before treatment is started unless we are instructed otherwise.) |
| [ ] | Call me after the physical exam and provide an estimate of any additional diagnostics or procedures. Do not proceed without authorization. I understand that if I cannot be contacted at this number no diagnostics or other treatments or procedures will be performed and I will assume all responsibility for any complications this decision may cause for my pet. |

_____Payment is expected when services are rendered. Should I fail to pay at any time any portion of the bill for my pet's care, I agree to pay the costs of all delinquency charges, collection charges and reasonable attorney's fees. I have read and understand this authorization of consent. I agree to pay the balance of all fees at the time of my pet's discharge.

Signature: _____ Date: _____

Phone number(s): _____

**Describe on the back of this form, the reason you are having your pet seen today.**