ANIMAL CLINIC EAST

1640 E Isaacs Avenue ♦ Walla Walla ♦ WA ♦ 99362

DROP OFF FORM

Owner Name: ______________________________ **Patient Name:** __________________

Email Address: _____________________________ **Email Reminders:** Y / N *(circle one)*

Today's Date: _____________________

Daytime Name/Phone Number: ____

Reason(s) pet is here: ____

____

How long has this been going on? ____

May we sedate your pet if the doctor deems it necessary? (additional fee applies) Yes / No
May we perform blood work if the doctor deems it necessary? (additional fee applies) Yes / No
May we perform x-rays if the doctor deems it necessary? (additional fee applies) Yes / No

Is your pet on any medications? (What type and how often?) ____________________________________

Did your pet have any medication today? Yes / No What time? ___________________________

Does your pet go outdoors? Yes / No

Is your pet on flea medication? (type and last date given) ______________________________________

If my pet is found to have transmissible conditions (such as fleas, ticks, ear mites) I give my permission for treatment. (For the protection of all, patient cannot be admitted without this permission) Yes _____ (initial)

If your pet is not current on vaccinations would you like us to update them today? Yes / No

What brand of food do you feed? ___________________________

When did your pet last eat? ________________________________

Have you observed any of the following in the past week? *(Please check all that apply)*

_____ Change in activity
_____ Straining to urinate
_____ Scooting
_____ Excessive drinking
_____ Shaking head/Scratching at ears
_____ Sneezing
_____ Vomiting
_____ Loss of appetite
_____ Increased urination
_____ Coughing
_____ Abnormal bowel movements

If your pet is ***not*** microchipped, would you like us to implant one today for $39? Yes / No

Any additional questions or comments?____

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I understand that payment is due in full upon my pet's discharge. My method of payment will be:

□ **Check** □ **Debit or Credit Card** □ **Cash** □ **Care Credit Account**

Signature ____ Date ____________________________

Updated & Scanned ☐ _________ (initials)