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? (addt'l fee applies) Yes / No
May we perform **blood work/urine** analysis if the doctor deems it necessary? (addt'l 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 recommended and required **vaccinations**, I understand vaccinations will be administered today at the doctor's discretion _____ (**initial**)
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 $41? Yes / No

Any additional questions or comments?_____

_____

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 _____