



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? (add'l fee applies) Yes / No

May we perform **blood work/urine** analysis if the doctor deems it necessary? (add'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 \$45? 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 _____