ANIMAL CLINIC EAST

1640 E Isaacs Avenue ♦ Walla Walla ♦ WA ♦ 99362

MEDICAL ADMISSION FORM

Appointment Date

Client Name:
Client Address:
City, State, Zip Code:
Phone:
Email Address:
Email Reminders: Yes ☐ / No ☐

Patient Name:
Dog ☐ Cat ☐ Other ☐
Breed Color
Spayed ☐ Neutered ☐ Intact ☐
Age: Weight:
Microchip#:

Daytime Name/Phone Number: (***if different than above***)

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/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) **(additional Fees apply)** 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 **(additional Fees apply)** _____ **(initial)**

What brand of **food** do you feed? Grain free? YES ☐ NO ☐

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	☐ Vomiting	☐ Straining to urinate
☐ Loss of appetite	☐ Scootin	☐ Increased urination
☐ Excessive drinking	☐ Coughing	☐ Shaking head/Scratching at ears
☐ Abnormal bowel movements	☐ Sneezing	

If your pet is ***not*** microchipped, would you like us to implant one today for $54? 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

Hospital Use Only Updated & Scanned ☐ _____ (initials)