

ANIMAL CLINIC EAST
1640 E Isaacs Avenue ♦ Walla Walla ♦ WA ♦ 99362

MEDICAL ADMISSION FORM

Appointment Date

Client Name: Patient Name:

Client Address: Dog Cat Other

City, State, Zip Code: Breed Color

Phone: Spayed Neutered Intact

Email Address: Age: Weight:

Email Reminders: Yes / No 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)*

- | | | |
|---|-----------------------------------|--|
| <input type="checkbox"/> Change in activity | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Straining to urinate |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Scooting | <input type="checkbox"/> Increased urination |
| <input type="checkbox"/> Excessive drinking | <input type="checkbox"/> Coughing | <input type="checkbox"/> Shaking head/Scratching at ears |
| <input type="checkbox"/> Abnormal bowel movements | <input type="checkbox"/> Sneezing | |

If your pet is **not** microchipped, would you like us to implant one today for \$58 ? 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

Updated & Scanned (initials)