

For patients that are spending the day for diagnostics

# PATIENT DROP-OFF FORM

Name of Owner:
Name of Pet:
Age of Pet:
<input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other

Phone numbers where you can be reached:	Whose number is this?
<b>1st</b>	
<b>2nd</b>	
<b>3rd</b>	

Which topical Flea Treatment are you using: \_\_\_\_\_ Date of last application: \_\_\_\_\_

Which Heartworm Preventive are you using: \_\_\_\_\_ Date of last treatment: \_\_\_\_\_

**Please fill out in as much detail as possible**

? Problem / Complaint / Services to be performed / Additional Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

? When did you first notice the condition: \_\_\_\_\_


? Is this a reoccurring problem and if yes, when was the last time: \_\_\_\_\_

? Has it become progressively worse: \_\_\_\_\_

? Is your pet on any **medications**: (please list them and when you gave them last) \_\_\_\_\_

? Have you noticed any of the following symptoms? Please check off what applies to your pet.

- |                                   |   |   |                                   |
|-----------------------------------|---|---|-----------------------------------|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Itchy Skin     | <input type="checkbox"/> Lameness |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Increased Drinking   | <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Pain     |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Increased Urinations | <input type="checkbox"/> Fleas & Ticks  | <input type="checkbox"/> Worms    |

 It might be necessary to sedate your pet to facilitate treatment or diagnostics, also to relieve stress and anxiety to the animal and to protect the staff that will be involved in the treatment / procedures.

If necessary, do you give permission to sedate your pet:  YES     NO     CALL ME

**(Please read carefully)**

I, the undersigned, hereby confirm that I am the legal owner / agent of the animal described above. I am authorizing the staff of Hilton Animal Hospital to administer treatment, perform diagnostic and prophylactic procedures, and care for my pet as deemed necessary by the attending veterinarian. Hilton Animal Hospital or its staff will not be held responsible in any manner whatever or any circumstance, on account of the care, treatment, or safe keeping of the animal described above or otherwise in connection therewith.

I bare full financial responsibility for any and all costs incurred for the treatment and care of my pet, and I am aware that all outstanding accounts are payable in full after services are rendered. Any Account not paid in full will incur finance charges, and possible collections and attorney's fees.

In the case of an emergency I understand that every reasonable effort will be made to contact me. Until I can be contacted, I hereby authorize the staff of Hilton Animal Hospital to administer treatment and care to my pet as deemed necessary by the attending veterinarian. I understand that every reasonable effort will be made to treat my pet and I will bare full financial responsibility for any costs incurred.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date