PET DROP OFF INFORMATION

Client Name: _____

Telephone Number to reach you today: _____

Pet's Name: _____ **Breed:** _____

Has your pet been seen by us before? [ ] Yes [ ] No (if not, please fill out a Client Registration form)

When was your pet's last meal? _____ **What did he/she eat?** _____

What medications (if any) has your pet received in the last 24 hours?

Name of medication:	**Amount given**	**What time**

Is your pet sensitive or allergic to any medications or food [ ] no [ ] yes

(please list) _____

What vaccinations, if needed, would you like us to give your pet today?
[ ] Rabies [ ] Distemper-Parvo [ ] Feline upper respiratory [ ] Feline Leukemia

Please describe the problem(s) your pet is having, pertinent history leading up to the current condition, any previous major medical problems, and what you would like us to do below:

_____
_____
_____

Would you like us to:
[ ] treat your pet after examination?
[ ] call you with the findings of the examination and an estimate of treatment cost prior to our treating your pet?
* Please note that if we have not seen your pet before, we will need to be able to contact you regarding your pet's examination prior to instigating any treatments.

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED

In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the veterinarians of PAWS AND CLAWS MEDICAL CENTER, and their support staff, to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.

Signed: _____ **Date:**_____