



# Patient Drop-Off Information

Today's Date: \_\_\_\_\_

### Client Information:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Pet Information:

Name: \_\_\_\_\_ Species:  Canine  Feline  Other: \_\_\_\_\_ Breed: \_\_\_\_\_  
Age/DOB: \_\_\_\_\_ Sex:  Male  Female  Spayed  Neutered Color: \_\_\_\_\_

Has this pet been seen previously at the BPVC?  Yes  No

If no, we recommend that you meet directly with the doctor for an initial examination and consultation.

Why did you bring your pet in today?  My pet is sick

- Annual Wellness Exam with Vaccinations
- Anal gland expression
- Canine Infectious Disease Test (Heartworm Test)
- Fecal Exam
- Pedicure
- Bloodwork: \_\_\_\_\_

Is your pet currently taking any medications? (please indicate name and dose)

- Heartworm preventative
- Flea/Tick Preventative
- Insulin
- Seizure Medications
- Heart Medications
- Other: \_\_\_\_\_

Has your pet been exhibiting any of the following symptoms? (check all that apply)

- Vomiting
- Diarrhea
- Coughing
- Wheezing / Difficulty Breathing
- Inappropriate Urination
- Decreased appetite
- Lethargy
- Depression
- Exercise intolerance
- Lameness
- Seizures
- Trouble walking
- Head shaking
- Scratching
- Allergies
- Bad Breath
- Swellings / Lumps
- Skin problems
- Eye problems
- Behavioral problems

For any symptom that you marked above, please describe in more detail.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did your pet last eat? \_\_\_\_\_

Do you need any refills of medications today?  No  Yes: \_\_\_\_\_

What time would you like to pick up your pet? \_\_\_\_\_ Would you like us to  call or  text when finished?

### Authorization of Care:

I authorize the BPVC to perform the following diagnostics before notifying me:

- Bloodwork
- Urinalysis
- X-rays
- Ultrasound

I authorize that I am over 18 years of age, the owner or duly assigned agent of the above listed pet. I authorize that Dr. G. Jay Crissman, Dr. Tracy Walker and staff of the Beverly Pike Veterinary Clinic may treat my pet today.

I authorize treatment up to the cost of \$ \_\_\_\_\_. Please call me if the treatment estimate is above this amount. I understand that this may cause a delay in the treatment until the doctor is able to reach me.

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Date