



Patient Drop-off Form

Patients for drop-off exams will be seen between regular appointments and after emergencies.

Date: ____/____/____

Pet's Name: _____ Last Name: _____

Type of Drop-Off: Surgery Exam Dentistry Other: _____

Reason for Exam: please explain condition(s) and symptom(s)

What time did your pet last eat? _____AM/PM

What time did your pet take last medications if any?

Name of Medication: _____ AM/PM

Name of Medication: _____ AM/PM

Name of Medication: _____ AM/PM

Name of Medication: _____ AM/PM

If your pet's vaccination(s) are due, do we have your permission to update them during this visit?

Please Circle YES NO

Treatment Authorization - Please choose one of the following

_____ I authorize any and all diagnostic(s)/treatment(s) the doctor deems necessary.
initial

_____ I authorize diagnostic(s)/treatment(s) up to the amount of \$ _____.
initial

_____ Please call me before performing any diagnostic(s)/treatment(s).
initial

_____ I understand that Animal Medical Center is not responsible for any lost/damaged items (including, but not limited to, leashes, collars, bedding, clothing) that are left with my pet during boarding.
initial

Owner's Signature: _____

Date: _____

Print Name: _____

Phone #: _____

Emergency Contact Person: _____

Emergency Contact #: _____