

# Webb Bridge Animal Hospital

## DROP OFF FORM

In an effort to provide the best care we ask that you take a moment to complete the following form prior to leaving your pet.

Owner: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Pet's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Describe your pet's diet: \_\_\_\_\_

List your pet's current medication(s): \_\_\_\_\_

Currently on Heartworm prevention?  No  Yes Brand: \_\_\_\_\_ Year round?  No  Yes

Primary reason for your pets visit with us today:

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

Please check any medical symptoms or problems you've noticed with your pet:

- |   |   |   |                                   |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> Appetite Loss      | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Loss of Balance              | <input type="checkbox"/> Thirst   |
| <input type="checkbox"/> Bad Breath         | <input type="checkbox"/> Eye Disorders      | <input type="checkbox"/> Mouth Sensitivity/Drooling   | <input type="checkbox"/> Gagging  |
| <input type="checkbox"/> Behavioral Changes | <input type="checkbox"/> Urination Increase | <input type="checkbox"/> Scooting                     | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Gums Bleeding      | <input type="checkbox"/> Skin/Coat Condition or Odor  | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Changes in Weight  | <input type="checkbox"/> Shaking Head       | <input type="checkbox"/> House / Litter Box Training  | <input type="checkbox"/> _____    |
| <input type="checkbox"/> Coughing           | <input type="checkbox"/> Sneezing           | <input type="checkbox"/> Itching, Licking, Scratching | <input type="checkbox"/> _____    |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Limping            | <input type="checkbox"/> Stiffness or Pain on Rising  | <input type="checkbox"/> _____    |

By dropping off your pet you agree to a physical exam by a doctor for a fee of \$48.00. Please check below for permission for any additional treatment.

- I authorize any treatment needed for the problems I have stated above.
- I wish to be called prior to any treatment.

Please check if you give us permission to do blood work which is an additional fee of \$80.00 to \$125.00.

- Yes
- No

**Owner's Signature:** \_\_\_\_\_