ABC Animal Clinic
1030 Piedmont Rd Suite A
San Jose, CA 95135
(408) 929-6767

Drop Off Treatment Form

Patient _____ Owner _____ Date _____
Breed _____ Sex M MC F FS Age _____

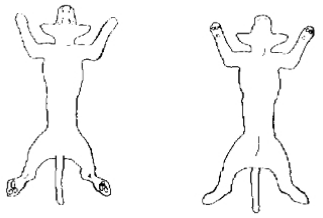
What will we be seeing your pet for today? _____
_____
_____

Primary Complaints:

___ Vomiting ___ Blood in urine ___ Itching ___ Painful ___ Diarrhea ___ Coughing ___ Hairloss
___ Growth/Lump ___ Blood in stool ___ Sneezing ___ Lethargic ___ Ears ___ Inappropriate Urination
___ Difficulty Breathing ___ Anorexia ___ Eyes ___ Difficulty Urinating ___ Lameness/Limping
___ Increased thirst ___Other: _____

If your pet has any unusual; lumps, bumps, wounds or skin irritation which you would like the doctor to address today, please note the location of each on the diagram. _____
_____
_____

Left (Back) Right Right (Belly) Left



Has your pet had an increase or decrease in any of the following: ***(Please circle one)***

Drinking	Increased	Decreased	No Change
Appetite	Increased	Decreased	No Change
Urination	Increased	Decreased	No Change
Defecation	Increased	Decreased	No Change
Weight	Increased	Decreased	No Change

Was your pet fed today? ___ Yes ___ No Time of meal? _____
Is your pet current on vaccinations? _____ Date give? _____
Any previous illness/surgery? _____
Is your pet on any medications/flea control? (list) _____
What is your pet's diet? _____
Has your pet been seen by another veterinarian for treatment? _____
May we call for records? ___ Yes ___ No If yes, name of clinic? _____
Any other issues you would like addressed? _____

Please read and initial ONE of the following:

_____ I authorize testing and treatment per estimate given and place no limit on additional charges/services deemed necessary by the veterinarian.
_____ I authorize testing and treatment per estimate given and approve charges up to an additional $_____.
_____ Please call me with an estimate before performing any procedures not outlined on the estimate given. If I cannot be reached, I authorize additional treatments deemed necessary by the veterinarian.
_____ Please call me with a revised estimate before performing any additional procedures not outlined on the estimate given. I understand that if I cannot be reached, my pet will receive NO treatments, except in the case of an emergency, other than those outlined on the original estimate.

Please read and initial the following:

_____ I hereby give my consent to ABC Animal Clinic to perform an exam and treatment(s).

Signature of Owner/Agent_____ Date_____

Primary Phone No. Today_____ Name of Contact_____

Alternate Phone No. 1)_____ 2) _____

*** **Note: There is a $15.00 hospitalization charge for the day for all drop off exams** ***