



# Patient Drop Off History Form

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

Owner name \_\_\_\_\_ Pet's name \_\_\_\_\_

We will need to be able to contact you or someone with permission to make medical and financial decisions.

Who will we be speaking with? \_\_\_\_\_

1<sup>st</sup> choice phone number \_\_\_\_\_

2<sup>nd</sup> choice phone number \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**Vaccines:** Check all that you would like done

*\*An exam is performed before all procedures and vaccines are administered (\$39.95)*

**Dog**

\_\_\_ Rabies (\$24.95)

\_\_\_ DACPP (\$26.95)

\_\_\_ Bordetella (\$19.95)

\_\_\_ Leptosporosis (\$16.95)

\_\_\_ DACPP + Lepto (\$35.95)

\_\_\_ K-9 Influenza (\$35.95)

\_\_\_ Lyme (\$35.95)

**Tests and Procedures**

\_\_\_ Fecal (\$30.95)

\_\_\_ Multi-part Fecal (\$49.95 or \$19.00 w/ plan)

\_\_\_ Heartworm/Lyme/Ehrlichia/Anaplasma test (Dogs) (\$60.95 w/out prevention or \$34.74 w/ prevention)

\_\_\_ Feline Leukemia/FIV/Feline Heartworm (Cats) (\$34.95)

\_\_\_ Routine blood work (\$130.85)

\_\_\_ Ear swab (\$32.95)

\_\_\_ Radiographs (\$179.95)

**Cat**

\_\_\_ Rabies (\$24.95)

\_\_\_ FVRCP (\$24.95)

\_\_\_ FeLV (\$24.95)

**Other Services:**

\_\_\_ Anal Gland Expression (\$24.95)

\_\_\_ Nail trim (\$14.95 with dremmel \$30.95)

\_\_\_ Microchip (\$45.00)

*\*All prices are without the wellness plan discounts.*

What diet is your pet eating? \_\_\_\_\_

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

Has your pet ever had an adverse reaction to any vaccines or any procedure? \_\_\_\_\_

If yes, please describe \_\_\_\_\_

Do you need a refill on any of your preventative medications? \_\_\_\_\_

**Heartworm Prevention Refill:**

\_\_\_ Heartgard

\_\_\_ Proheart

\_\_\_ Revolution

**Flea/Tick Prevention Refill:**

\_\_\_ Nexgard

\_\_\_ Bravecto

\_\_\_ Revolution

Please list any medication that your pet is taking:

Medication	Dosage/Frequency	When last dose was given

Have you noticed any changes or do you have any concerns about any of the following in your pet?

- Eating more/Less
- Drinking more/less
- Bad Breath
- Weight gain
- Weight loss
- Urinating more/less
- Vomiting
- Diarrhea
- Itching/Scratching
- Difficulty rising
- Scooting rear
- Shaking head
- Masses
- Hair loss
- Limping
- Other \_\_\_\_\_

Please describe your concerns- include how long you have noticed the concern and how it has progressed over time. How frequently is it happening?

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Is this the first time you've noticed this issue? \_\_\_\_\_

Have you tried any treatment? Did it help? \_\_\_\_\_

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**\*\* Payment is expected at the time services are rendered\*\***

We accept cash, check, Visa, MasterCard, American Express and Discover

For delayed payment options we offer Care Credit

I, the undersigned owner or authorized agent of the above admitted patient, hereby authorize the doctors of My Pet's Vet to administer such treatment as in necessary and perform procedures therapeutically and/or diagnostically. I further understand that no guarantee of successful treatment is made. I also assume financial responsibility for all charges incurred, and agree to pay all such charges up to \$\_\_\_\_\_ or unlimited, at the time of release. If charges will exceed the authorized amount, My Pet's Vet will make our best effort to contact you for authorization of additional services. If we are unable to reach you, we will not be able to provide additional services.

Signature of owner/agent \_\_\_\_\_ Date \_\_\_\_\_