Edmonds-Westgate Veterinary Hospital, P.S.

AAHA ACCREDITED The Standard of Veterinary Excellence

Patient Drop Off Form

Date _____

Name _____ _____
(Last) (Pet Name)

Primary phone number to reach you today: _____

Backup phone number: _____

Reason for visit:

_____

How long has your pet experienced these symptoms? _____

Is your pet:	Normally	Abnormally
Eating	_____	_____
Drinking	_____	_____
Urinating	_____	_____
Passing Stool	_____	_____

If "Abnormally," please describe _____

_____

Please check all boxes that apply to your pet's current condition

☐ Blood in Stool
☐ Breathing Problems
☐ Coughing
☐ Diarrhea
☐ Decreased Appetite
☐ Ear Problems
☐ Eye Problems
☐ Gagging
☐ Hair Loss
☐ Increased Thirst
☐ Increased Urination
☐ Itchy
☐ Lameness/Limping
Where: _____
☐ Loss of Balance
☐ Not Acting Like Self
☐ Painful
Where: _____
☐ Sneezing
☐ Shaking Head
☐ Vomiting
☐ Weakness
☐ Weight Change
☐ Wound(s)
☐ Other: _____
_____
_____

** **Full payment is due at time services are rendered** **

Today's visit will be a minimum of $77.50

*Please initial **ONE** of the following options:*

____ **Call with an estimate for diagnostic testing/treatment that require additional cost.**

____ **I authorize treatment for my pet as deemed necessary by the veterinarian.**

Signature: _____

** **Please let us know if you require an estimate at any time.** **