



Phone 214-369-4997

Medallion Animal Clinic

Fax 214-369-5866

Drop-off Form

Client Name _____ Patient Name _____

Date when symptoms started? _____

Is your pet:

- | | | |
|---|---|--|
| <input type="checkbox"/> Eating normally | <input type="checkbox"/> Not Eating | <input type="checkbox"/> Eating ravenously |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Gagging | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Diarrhea w/blood | <input type="checkbox"/> BM Straining |
| <input type="checkbox"/> Lethargic | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Straining to urinate | <input type="checkbox"/> Urinating Blood | <input type="checkbox"/> Scooting |
| <input type="checkbox"/> Shaking Head | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Scratching | | |

_____ Limping-which leg? ___Right Front ___Left Front ___Right Rear ___Left Rear

Please give us any information about your pet that can assist us:

Is your dog on heartworm preventative? ___ Yes ___ No

When and where did your pet have their last vaccines? _____

I authorize the Dr. to spend up to \$_____ (Minimum of \$110.00) in diagnostics prior to contacting me.

If we cannot reach you to discuss the results of the diagnostic tests, do you want us to proceed with treatment? ___ Yes ___ No

Phone number where you can be reached: _____

___Home ___Work ___Pager ___Cell

I agree that I am the owner of this pet and allow the doctor(s) at Medallion Animal Clinic treat my pet. Furthermore, I agree to pay for all charges that are incurred and I understand full payment is required at discharge.

Owner's/Agent Signature _____ Date _____