5785 S. Greenville Rd – Greenville, MI 48838

ORCHARD VIEW VETERINARY CLINIC

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DROPOFF FORM

Today's Date:_____/_____/_____

Owner/Caregiver: Mrs._____ Mr._____ Ms._____ Dr._____

First Name:_____ MI:_____ Last Name:_____

Home Phone:_____ Work:_____Cell:_____

Email Address:_____

Driver's License or I. D. Card Number: _____ Expiration Date:_____

What is your preferred form to receive immediate communication from us?

Home Phone_____ Cell Phone_____ Email_____ Text Message_____ Work Phone_____

We have arranged for you to leave your pet here, to allow Dr. Tammy Brodie to examine your pet as soon as possible today. Please read through the following questions, and answer any that may apply to your pet today. Please read and sign the authorization form.

Please note: Your privacy is important to us. All information received in all forms and though other communications is subject to our Patient Privacy Policy.

Everything was okay with my pet until_____. Since then,

My pet is lethargic (sluggish, inactive, lifeless)_____

Water intake has a) decreased, b) increased, c) unchanged

My pet last ate normally on this date_____

My pet last ate anything on this date_____

The last thing my pet ate was_____

My pet started vomiting_____

What color?_____

How often is your pet vomiting?_____

What substance? (food, foam, bile?)_____

My pet last vomited_____

My pet has normal stools_____

My pet seems constipated_____

My pet started having diarrhea on this date_____

What color?_____

What consistency?_____

Has your pet had access to foods other than recommended pet food?_____

I have given my pet this medication_____. Did it help? Yes or No

My pet has lost_____ or gained_____ weight.

My pet is lame_____, or sore_____, or has been injured_____.

I think his/her_____is bothering him/her.

This started_____. It has worsened_____or, improved_____some.

This has never_____,or has recently_____happened, or is a long time (chronic) problem_____.

Please describe in your own words what seems to be the problem and circle the body part on the diagram that you think is the problem.

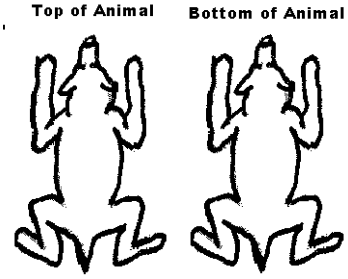
_____

_____

_____

_____

_____



I, the owner/agent for the described animal, authorize and request an exam for my pet. I understand that sedation and/or pain medication will be provided if deemed reasonable. I understand Dr. Tammy Brodie or her staff will contact me after she has examined my pet to discuss recommended diagnostics and treatment. I understand at this time I will be given an initial treatment plan of charges. I can be reached at any of the phone numbers I have provided.

If I cannot be reached at any of the numbers listed on this form, I authorize initial diagnostics, including radiographs, and blood work if indicated for my pet. Further, if I cannot be reached following diagnostics, I authorize initial treatment, including fluid support and other supportive medications be started as indicated for my pet.

I authorize anesthesia, surgery and medications if needed for abscess, laceration or other wounds, if my pet is presented for one of these problems. I understand, and accept that when anesthesia is involved, there are always inherent risks, including death.

I understand payment is due when my pet is discharged. However, a deposit may be required after a treatment plan is prepared and discussed. I accept financial responsibility for charges incurred for this pet.

I understand that I will be charged for flea medication and a dose will be applied if evidence of fleas is found on my pet today.

Signature:_____ Date:_____

FINANCES

I authorize the use of my card number to be used by Orchard View Veterinary Clinic to pay for any medical expenses that my pet(s), listed above, may require. I am aware that my credit card number will be kept on file but will be stored in a private and confidential manner. I authorize a maximum of $_____ to be used towards my pets care, at Orchard View Veterinary Clinic.

Please circle method of payment: Debit/Credit card, Check, Cash, Care Credit

Please circle which card:

Visa/MasterCard/Discover/AmericanExpress/Care Credit Number:_____

ExpDate:_____

Security Code on Back of Card:_____

Name (as it appears on the card):_____

Cardholders Signature:_____