



Medical Care Patient History Form

Drop-Off Appointment

Owner's Name: _____ Pet's Name: _____
Last, First

Contact #'s _____ Best Time to Call: _____
For Today: #1 #2

What problem is your pet presenting with? _____

When did you first notice the problem? _____

Has the problem changed since you noticed it? (please circle) YES NO
If yes, how? _____

Has your pet had this problem before? (please circle) YES NO
If yes, when? _____

Is your pet eating? (please circle) YES NO Don't Know

Is your pet drinking? (please circle) YES NO Don't Know

If there is anything else you would like the doctor to know, please describe below:

What medications, vitamins, or nutritional supplements has your pet received recently?

| Name of Product | Date Given | Amount |
|-----------------|------------|--------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Is your pet allergic to any medications or had a reaction to any? (please circle) YES NO
If yes, explain: _____

Are you leaving anything with your pet today (leash, bed, medication, etc)? YES NO
If yes, please describe: _____

Best Friends Animal Hospital does not charge for keeping your pet for outpatient services. If more intensive care is required, hospitalization charges could apply. You would be contacted for authorization before any such treatment was initiated. To treat &/or diagnose your pet our doctors may only need an examination, or we may need additional tests. In an effort to diagnose &/or treat your pet's condition as quickly as possible, please select from the level of initial care you will consent to without prior contact and specific authorization.

Please circle the phrase that expresses your wishes:

Up to \$100

Up to \$200

Up to _____

Your choice will in no way alter the recommendations we have for your pet's care. We have had difficulty contacting some owners however to get their approval when their pet needed immediate treatment. The doctor will contact you before any treatment is done that exceeds your approval above.

Consent for Exam, Treatment, and/or Surgery:

I am the owner, or a representative of the owner, of the animal(s) presented & have the authority to execute this consent. I authorize & direct the veterinarians of Best Friends Animal Hospital (& their designated assistants) to administer authorized treatment as needed on the basis of findings during the course of evaluation: to diagnose, prescribe, sedate, anesthetize, perform therapeutic procedures &/or surgery as their judgment may dictate to be advisable for the patient's well being. I understand I will be advised as to the nature of the procedures & the risks involved. I understand that no warranty or guarantee will be made as to the results or cure. An estimate of these fees will be provided at my request for the initial assessment & treatment for the patient(s) presented. I realize that actual expenses may differ from the estimate dependent on the patient's condition & length of stay in the hospital. Best Friends will try to contact me if emergency treatment is required. I also understand & will be responsible for expenses incurred in an emergency when I cannot be reached or there is no time to contact me. I will be fully responsible for monitoring the ongoing expenses & will be fully responsible for all expenses incurred through the animal's diagnosis & treatment.

~ All fees are expected to be paid in full upon completion of the visit. ~

~ A deposit is required if the patient is being hospitalized. ~

Owner's Signature: _____ Date: _____

In-House Use Only Below Line

DBS CAS KJS _____ @ _____ am / pm

History Charges CB __d Owner Called: LMOM / NA / Spoke to @ _____ am / pm

Pet RTG _____ Pending _____

Meds: YES NO RTG In Fridge Written Rx

Notes: _____