

CENTRE COURT VETERINARY CLINIC

Phone: 404 252-9200

Fax: 404 252-0490

PET DROP OFF INFORMATION

Client Name: _____

Telephone numbers to reach you today: _____

Pet's Name: _____

Breed: _____

Has your pet been seen by us before? Yes No (if not, please fill out a Client Registration form)

When was your pet's last meal? _____ What did he/she eat? _____

What medications (if any) has your pet received in the last 24 hours?

Is your pet sensitive or allergic to any medications or food no yes
(please list)

What vaccinations, if needed, would you like us to give your pet today?

DOG

Rabies Distemper-Parvo Bordetella Fecal Heartworm test Yearly blood work screening All needed vaccinations

CAT

Feline upper respiratory Feline Leukemia Leukemia/FIV test Fecal Yearly blood work screening All needed vaccinations

Please describe the problem(s) your pet is having, pertinent history leading up to the current condition, any previous major medical problems, and any other information that I may need to know:

Would you like us to: treat your pet after examination? call you with the findings of the examination and an estimate of treatment cost prior to our treating your pet? * Please note that if we have not seen your pet before, we may need to be able to contact you regarding your pet's examination prior to starting treatment.

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED
In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the veterinarians of Centre Court Veterinary Clinic, and their support staff, to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.

Signed: _____ Date: _____