



*Atlantic*  
VETERINARY HOSPITAL

***Drop-Off Appointment Form***

Your Name: \_\_\_\_\_ Pet's Name: \_\_\_\_\_

Phone number(s) where we can reach you today (circle best number): \_\_\_\_\_

What time would you like to pick up? \_\_\_\_\_

(We will try our best to accommodate your schedule. Please discuss your expectations with the receptionist so we may set a realistic time frame.)

Please briefly describe problem/concern \_\_\_\_\_

Current diet (please include brand, type, and amount fed each day) \_\_\_\_\_

Treats (type and amount) \_\_\_\_\_

Current medications: \_\_\_\_\_

Last dose given at: \_\_\_\_\_

Recent changes in behavior or habits? ( ) No ( ) Yes

Please describe any recent changes in behavior, activity level, urination, defecation, water consumption, appetite, breathing, skin, hair coat, odor, gait, posture, or any other concern. Please include the date(s) you first noticed the change: \_\_\_\_\_

Recent change in weight? ( ) No ( ) Yes Please describe time frame and estimated amount: \_\_\_\_\_



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Any recent	Coughing	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sneezing	<input type="checkbox"/> No <input type="checkbox"/> Yes
	Vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diarrhea	<input type="checkbox"/> No <input type="checkbox"/> Yes
	Constipation	<input type="checkbox"/> No <input type="checkbox"/> Yes	Limping	<input type="checkbox"/> No <input type="checkbox"/> Yes

I give Atlantic Veterinary Hospital permission to examine my pet.

I authorize necessary diagnostic tests and treatment up to \$ \_\_\_\_\_

I do not authorize any diagnostic testing without first discussing them with the veterinarian by phone. I understand that if I cannot be reached by phone, no testing or treatment will be performed.

Signature \_\_\_\_\_

Date \_\_\_\_\_