St. Francis Animal Hospital Patient:_____ Age: _____ Date:_____

Drop Off Treatment Form Owner:_____

Phone: (706) 860-6617 Email: appts@sfah.net Weight:_____(Tech) Temp:_____(Tech)

What will we be seeing your pet for today?_____

_____

Primary Complaints *(Circle All that apply):*

Vomiting	Diarrhea	Blood in Stool	Blood in Urine	Inappropriate Urination	Difficulty Urinating	Increased Thirst
Anorexia	Lethargic	Hair loss	Itching	Sneezing	Difficulty Breathing	Coughing
Eyes	Ears	Painful	Lameness/Limping: Left Front	Right Front	Left Rear	Right Rear
Growth/Lump/Wound Location:		**This form is your primary communication to the doctor. Please fill it out thoroughly, and note any concerns that need to be addressed today.** ***Drop Off Walk Ins Only: For Drop Off appointments we will call you as soon as we complete the exam to discuss treatment recommendations and discharge time. *** **PLEASE NOTE THAT IF YOU CHOOSE TO WAIT ON YOUR PET AFTER DROP OFF, WE CAN NOT GUARANTEE WAIT TIMES.**				

Please circle one below. ***How long has this been going on/when did it start.***

Drinking: Increased Decreased No Change _____
Appetite: Increased Decreased No Change _____
Urination: Increased Decreased No Change _____
Defecation: Increased Decreased No Change _____
Is your pet indoors or outdoors? _____
Is your pet current on vaccinations? _____ Date given? _____ Where?_____

Is your pet on any medications? (list daily & monthly) _____
_____

Does your pet have any chronic health issues or previous surgeries? _____

If possible, today do you want any of the following done:

_____ Update Vaccines (w/Exam) _____ Nail Trim ($19-29) _____ Anal Gland Expression ($24) _____ Clean Ears ($20)

Monday thru Friday the examination fee is $65. The examination with core vaccines included is $85. Additional Fee for Walk Ins- see below

***Current Patient Non- Scheduled Fee $25 /New or Lapsed Patient $40. For ADDITIONAL treatment please select an option below.**

Saturday the examination fee is $100. The examination with core vaccines included is $125.

What amount of money can be spent on diagnostics, treatments, etc. without further consent? *(please initial).*

Exam fee + _____$150-$300 _____ $300-$600 _____Unlimited _____ Other - please specify ($)

Payment will be due in full when services are rendered & deposits will be asked for urgent care.

Signature of Owner/Agent_____ Date_____

***Name of Contact for the phone number listed below**_____

Phone No. 1)_____ Alternate 2) _____

Email _____ TECH INITIALS: _____

We can text! If you have difficulty reaching us by calling or prefer you can message us at (706)860-6617!