

**PATIENT DROP-OFF FORM**



JET CITY ANIMAL CLINIC  
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**MEDICAL RECORD - HOSPITAL USE ONLY**

CLIENT ID # \_\_\_\_\_  
CLIENT NAME \_\_\_\_\_  
PATIENT NAME \_\_\_\_\_

DATE: \_\_\_\_\_ **To help us provide the best care, please complete the following:**

WHY ARE YOU PRESENTING YOUR PET FOR AN EXAM TODAY? PLEASE INCLUDE SYMPTOMS AND DURATION:

\_\_\_\_\_

SINCE YOU FIRST NOTICED THE SYMPTOMS, IS YOUR PET:  BETTER  WORSE  THE SAME

IS YOUR PET CURRENTLY ON MEDICATIONS?  NO  YES - IF YES, PLEASE LIST TYPE AND DOSAGES: \_\_\_\_\_

\_\_\_\_\_ WHEN WERE MEDICATIONS LAST GIVEN? \_\_\_\_\_

HAS YOUR PET HAD UNUSUAL/UNEXPECTED REACTIONS TO MEDICATIONS OR VACCINES?  NO  YES - IF YES, PLEASE DESCRIBE BELOW:

\_\_\_\_\_

IS YOUR PET NOW TAKING PREVENTATIVE FOR TICKS/FLEAS?  NO  YES - IF YES, WHAT TYPE? \_\_\_\_\_

DO YOU KEEP YOUR PET(S)  INDOORS  OUTDOORS DATE OF LAST VACCINATION AND EXAM: \_\_\_\_\_

HAS YOUR PET TRAVELED OUT OF WASHINGTON?  NO  YES - IF YES, WHERE AND WHEN? \_\_\_\_\_

WHAT TYPE OF FOOD DO YOU CURRENTLY FEED YOUR PET? \_\_\_\_\_

HOW MUCH/OFTEN? WHEN IS THE LAST TIME YOUR PET HAS EATEN? \_\_\_\_\_

HAS YOUR PET LOST OR GAINED WEIGHT RECENTLY?  NO  YES - IF YES, HOW MUCH/WHAT PERIOD? \_\_\_\_\_

HAS YOUR PET'S WATER INTAKE CHANGED?  NO  YES - IF YES, HOW MUCH/WHAT PERIOD? \_\_\_\_\_

HAS YOUR PET'S EXCRETORY HABITS CHANGED?  NO  YES - IF YES, HOW MUCH/WHAT PERIOD? \_\_\_\_\_

HAS YOUR PET BEEN TREATED FOR ANY MAJOR MEDICAL PROBLEMS/SURGERY?  NO  YES - IF YES, WHAT TYPE AND WHEN?

\_\_\_\_\_

**TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE**

I hereby authorize Jet City Animal Clinic (JCAC) to perform medical and initial diagnostic/surgical procedures on this animal as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors and assistants.

JCAC and it's staff are leaders and teachers in the veterinary medicine field, thus case information and/or photos may be used in teaching, forms continuing education, web site, veterinary literature, and the like. I authorize the release of case/patient information for such purposes.

In the event that I sell this animal to another owner, I authorize release of medical information to the new owner.

**FINANCIAL POLICY**

Payment is due as services are rendered. For hospitalized/admitted cases, a deposit is required in advance. The balance is due upon discharge from the hospital. Payments can be made by cash, personal check (with proper identification), and accepted credit cards, including Care Credit. If payment arrangements are needed, the undersigned realizes that they must be agreed upon prior to admitting patients. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.

*I have read and accept the preceding obligations.*

**BEST CONTACT PERSON & NUMBER FOR TODAY:** \_\_\_\_\_

**AUTHORIZING SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_