MOUNTAIN VIEW VETERINARY CLINIC
1333 PLAZA BLVD, SUITE E
CENTRAL POINT, OR 97502
(541) 664-4553

DROP OFF PATIENT INFORMATION

Client Name: _____ Patient Name: _____
Date of Visit: _____

APPETITE: ☐ GOOD ☐ FAIR ☐ POOR
When was the last time your pet ate? _____
What is your pet's normal diet? _____
Has your pet experienced any vomiting? ☐ YES ☐ NO
If yes, when did it start and how frequently is it occurring? Is there any blood?
_____

ELIMINATION
Bowel Movements:
☐ Normal ☐ Diarrhea ☐ Straining/Constipation ☐ Blood

PLEASE DESCRIBE ANY OTHER SYMPTOMS THAT ARE OF CONCERN:

_____
_____
_____
_____

WE STRIVE TO PROVIDE A FLEA AND TICK FREE ENVIRONMENT. FOR THIS REASON, YOUR PET WILL BE CHECKED FOR THESE PARASITES AND TREATED IF ANY ARE FOUND. THE CHARGE FOR THIS ONE MONTH PROTECTION IS $20.00.

Your pet will receive an examination while in our hospital. If any problems are found at that time or develop while your pet is in our care, I authorize and assume full financial responsibility for:

☐ Any tests/treatments deemed necessary for my pet.
☐ Any tests/treatments deemed necessary for my pet. (up to $100.00 or $_____)
☐ Do NOT administer any tests/treatments until you have spoken with me or my contact person.

TIME AVAILABLE FOR PHONE CONSULTATION WITH DOCTOR: _____
CONTACT PERSON: _____ PHONE: _____

Payment Is Due When Services Are Rendered Unless Other Arrangements Have Been Made In Advance.