


ANIMAL MEDICAL CENTER OF SOUTHERN CALIFORNIA

Patient Drop-Off Form

Patients for drop-off exams will be seen between regular appointments and after emergencies.

Pet's Name: " _____ " Last Name: _____

 Type of Drop-Off: Surgery Exam Dentistry Other _____

 Reason for Exam: explain condition(s)/symptom(s):

 What time did your pet last eat? ____: ____ AM/PM

 What time did your pet take last medications if any?

Name of Medication: _____ : ____ AM/PM

Name of Medication: _____ : ____ AM/PM

Name of Medication: _____ : ____ AM/PM

Name of Medication: _____ : ____ AM/PM

 If your pet's vaccination(s) are due, do we have your permission to update them during this visit? (Please Circle) YES NO

Treatment Authorization *Please choose one of the following*

_____ I authorize any and all diagnostic(s)/treatment(s) the doctor deems necessary.
initial

_____ I authorize diagnostic(s)/treatment(s) up to the amount of \$_____.
initial

_____ Please call me before performing any diagnostic(s)/treatment(s).
initial

Owner's Signature: _____ Date: _____

Print Name: _____ Phone #: _____

Emergency Contact Person: _____ Emergency Contact #: _____