Village Veterinary Hospital

Drop Off Form

Please provide the following information so we can be certain that we understand your pet's needs, it is very important for you to be as specific as possible. If we need additional information, we can reach you at the number you give us today. Thank you.

Owner's Name: ___________________________________ Date: ____

Pet's Name: ____

is address & phone number on record still current? Yes No

New Address/Ph # ____

Phone number where you can be reached today Yes No

Alternate Phone Number: ____

is your pet sick? Yes No Problem: _____________________

Has pet been treated for same condition recently? Yes No

What: ____

Medications: _____________________________________ Last Given: ___________________________________

Current diet: ____________________ No. feedings per day: _____ How Much? _______________________

Diet supplement given: ____

Is the pet currently on Heartwonn Prevention Yes No Type: ____________________________

History:

Any injury or accident in the past 30 days? Yes No

What happened: ____

Had surgery in the past 30 days? Yes No

What: ____

Currently on any medications? Yes No What? ________________________

Allergic to any medications? Yes No What? ________________________

Appetite normal? Yes No How Long _____________________

Vomiting? Yes No How Long _____________________

Diarrhea?	◯ Yes	◯ No	How Long ____________________
Listless?	◯ Yes	◯ No	How Long ____________________
Drinking more or less water than usual?	◯ Yes	◯ No	How Long ____________________
Urinating more than usual?	◯ Yes	◯ No	What? ______________________
Weakness?	◯ Yes	◯ No	What? ______________________
Coughing?	◯ Yes	◯ No	How Long ____________________
Sneezing?	◯ Yes	◯ No	How Long ____________________
Gagging?	◯ Yes	◯ No	How Long ____________________
Scratching?	◯ Yes	◯ No	How Long ____________________
Flea Control?	◯ Yes	◯ No	How Long ____________________
Shaking head?	◯ Yes	◯ No	How Long ____________________
Limping?	◯ Yes	◯ No	How Long ____________________
Scooting?	◯ Yes	◯ No	How Long ____________________
History of seizures?	◯ Yes	◯ No	How Long ____________________
Unusual lumps or bumps?	◯ Yes	◯ No	How Long ____________________
Bad Breath?	◯ Yes	◯ No	How Long ____________________
Weight loss or gain?	◯ Yes	◯ No	How Long ____________________

Unusual Discharge? ◯ Yes ◯ No Where? __________ How Long? __________________

Behavioral Changes?	◯ Yes	◯ No	How Long ____________________

Tests and Services Requested For Your Pet Today

Vaccinations:

Dogs: DA2P +Parvo	☐	Cats: FVRCP	☐
Bordetella Bronchitis	☐	FELV	☐
Corona Virus	☐	FIP	☐
Rabies	☐	Rabies	☐

Behavioral Changes? ◯ Yes ◯ No FELV/FIV Test ◯ Yes ◯ No

internal Parasite Exam ◯ Yes ◯ No

Deworm if needed ◯ Yes ◯ No

Bath/DIp ○ Yes ○ No

anything else we need to know ○ Yes ○ No

Some pets require sedation for adequate physical exam and/or treatments. may we sedate your pet if necessary? ○ Yes ○ No ○ Call First

After examination by the Doctor, may we proceed with tests and/or treatments? ○ Yes ○ Not to exceed ($)__________________ ○ Call First

Call the office by 1:00 pm to check on progress if we have not contacted you.

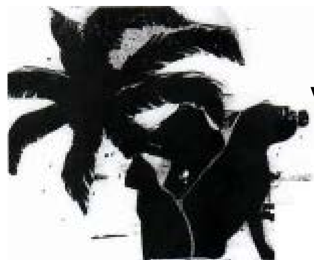
Consent for Treatment and/or Admission

I, the undersigned owner/agent of ________________________, conscent to the examination of this pet by staff veterinarians at The Village. I also agree that after a consultation with me, the hospital's doctor(s) may prescribe medication, treat, hospitalize, sedate , anesthetize and/or perform surgery on my pet. I understand that some risks with exist with anesthesia and/or surgery and that i am encouraged to discuss any concerns I have about those risks with the veterinarian before beginning the procedure. Should unexpected life-saving emergency care be required and the veterinarian or staff member is unable to reach me, the hospital staff has my permission to provide such treatment, and i agree to pay all fee incurred.

I understand that an estimate fees for all veterinary services can be provided to me and that I am encouraged to discuss all fees related to the care before services are rendered and during my pet's ongoing medical treatment. I understand the payment is due at the time of discharge. In some cases a deposit may be required.

_____________________________ _____________________________

Signature of Owner / Agent Date



Village Veterinary Hospital
7527 Draper Avenue
Ladolla,CA 92037
(858) 412-4776 92037

New Client/Pet Form

Date: ________________

Owner's First Name: ______________________________ Owner's Last Name ____________________________

Primary Phone: ________________________________ Secondary Phone ______________________________

Spouse or Co-Owner Name: _________________________ Home Phone_____________________________

Work Phone: ________________________________ Emergency Phone_____________________________

Address: ___________________________________ City:_______________ State:_________ Zip: ___________

Email Address: _____________________________________ Employer: _____________________________

How did you hear about us? ________________________

Referred by (We would like to thank them: ____________

NAME AND NUMBER OF PREVIOUS VETERINARIAN: _______

____

Are there other pets in your household? Yes No

If yes, please indicate quantity below:

Dogs:_______________ Cats: ________ Birds: ____

Reptiles: ________ Rabbits: _______ Other: _____

PET INFORMATION Male Female

Pet's Name: __________________________

DOB/AGE: ____________ Species: ________

Breed: ____________ Color: ________

SPAYED/NEUTERED Yes No

How long have you had your pet? _____________

Vaccination History (indicate the date dd/mm/yy- your pet last received the following vaccinations) - or - write NOT SURE

CANINE DHP: ________ Parvovirus:___________:

Bordetella: __________ Rabies: _____________

Other: ______________________________

FELINE Rabies: ___________ FVRCP: _________

Leukemia: ________ Other: ________________

DENTAL CARE

Do you brush your pet's teeth? Yes No

Date of last clinic dental cleaning? __________

Has your pet had any of the following in past week?

- Vomiting
- Diarrhea
- Cough
- Weakness/Lethargy
- Depression/ Attitude Change

Medical Conditions that we need to be aware of:
(allergies, drug reactions, heart conditions, etc.)

____

____

____

What is your primary reason for your visit today?

____

____

What does your pet eat?

Dry Brand: ______________________________

Canned Brand: __________________________

People Food: ___________________________