Peachtree Corners Animal Clinic, P.C.

Dr's. Mize, King, Brothers, & Jackson

Drop Off Form

Date:_____/_____/_____

Owner's Name:_____________________________ **Pet's Name:**_________________________________

Phone Number:____________________________ **Doctor Preference:**__________________________

Please mark your pets symptoms and explain in the space provided.

Vomiting	Diarrhea	Coughing	Ear Problems
Lameness	Difficult Urination	Sneezing	Constipation
Skin Problems	Lack of Appetite	Scratching	Other
Constipation	Lethargy	Eye Problems	

Explain:____

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Please mark the locations of any masses you would like looked at or removed on the diagram:

Number of days the problem has persisted: ________

Most recent meal: _________________________________

Type of food eaten: ________________________________

Last normal bowel movement: ____________________

Last urination: ____________________________________

Is your pet on any medication? YES | NO

Medication: _________________________________

Last Dose: __________________________________

Does your pet have any allergies? YES | NO Explain: ______________________________________

List any previously diagnosed conditions: ____

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I authorize whatever tests the doctor feels are NECESSARY in the treatment of my pet.

I authorize the above listed treatments and would like the doctor to call before any additional treatments are done.

I authorize the doctor to do necessary treatment up to $___________. Beyond that I would like the doctor to call me to discuss further treatments.

I would like the doctor to call me before ANY tests or treatments are done.

Signature:____ Date: ___________________________