

**FRANKFORD PET HOSPITAL**

3044 OLD DENTON RD #320

CARROLLTON TX 75007

972-242-7710 TEL

972-242-7651 FAX

**DROP OFF FORM**

**CLIENT**

**NAME** \_\_\_\_\_ **PATIENT** \_\_\_\_\_

**DATE WHEN SYMPTOMS**  
**STARTED** \_\_\_\_\_

IS YOUR PET:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> eating normally           | <input type="checkbox"/> not eating    | <input type="checkbox"/> eating ravenously |
| <input type="checkbox"/> breathing difficulties    | <input type="checkbox"/> gagging       | <input type="checkbox"/> coughing          |
| <input type="checkbox"/> diarrhea                  | <input type="checkbox"/> seizures      | <input type="checkbox"/> BM straining      |
| <input type="checkbox"/> lethargic                 | <input type="checkbox"/> urine/w blood | <input type="checkbox"/> scooting          |
| <input type="checkbox"/> straining to urinate      | <input type="checkbox"/> weight loss   | <input type="checkbox"/> weight gain       |
| <input type="checkbox"/> shaking head              |  |  |
| <input type="checkbox"/> limping (which leg _____) |  |  |

Please give any information about your pet that may further assist us:  
\_\_\_\_\_  
\_\_\_\_\_

Is your pet on heartworm prevention? yes no

When and where did your pet have their last vaccines? \_\_\_\_\_  
\_\_\_\_\_

I authorize the doctor in addition to the normal \$43 examination fee to spend up to \$\_\_\_\_\_ in diagnostics prior to contacting me. (Basic bloodwork costs between \$65 and \$150)

Phone number where you can be reached today \_\_\_\_\_

If we cannot reach you, do you want us to proceed with treatment? yes no

**I agree that I am the owner of this pet and allow the doctor(s) at Frankford Pet Hospital to treat my pet. Furthermore, I agree to pay for all charges that are incurred and I understand that full payment is required at time of pick up.**

Owner signature \_\_\_\_\_ Date \_\_\_\_\_