The Village Animal Hospital
Dr. Beatriz Segarra, DVM

Drop-Off Form

Date: ___/___/___

Owner:_____ Pet:_____

Phone Number:_____

Please mark symptoms, using the space provided for further explanation if needed

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

_____
_____
_____

Problem Duration: _____
Most Recent Meal: _____
Diet Type: _____
Last Normal Bowel Movement: _____
Last Urination: _____
Medications? _____
Last Dose: _____
Allergies? _____

Please mark the location of masses to be evaluated:

Previously Diagnosed Conditions:
_____
_____

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

_____ I authorize the above treatments ONLY and would like the doctor to call before any additional treatments are performed.

_____ I authorize all necessary treatment up to $_____. Beyond that I would like the doctor to call.

_____ I would like the doctor to call me before any tests or treatments beyond a physical exam.

Signature:_____ Date:_____