VETERINARY CENTER OF BUCKHEAD
DROP-OFF / HOSPITALIZATION FORM

CLIENT:	PATIENT:
DATE / TIME IN:	DATE / TIME OUT:
VACCCINATION STATUS:	DOCTOR: TECH:
REASON FOR VISIT:	ACCOUNT #:
SYMPTOMS:	BELONGINGS:

- Patient needs heartworm and/or flea & tick preventative (if yes, list brand) _____
- **CATS ONLY:** Indoor or Outdoor _____

ALL DROPPED OFF PETS WILL NOT BE READY UNTIL AFTER 3 PM

I hereby authorize the veterinarian to examine, prescribe for, or treat any medical conditions diagnosed during my pet's visit. I understand that my pet may be examined and treated by any of the four vets on staff (Dr. Lance Hirsh, Dr. Carrie Kroll, Dr. Greg Jenkins). ***I assume responsibility for all charges incurred during this care. I also understand that these charges must be paid at the time of discharge, WE DO NOT BILL!!!!*** A written estimate is available upon request.

CLIENT SIGNATURE: _____

CONTACT PHONE NUMBER(S): _____ DATE: _____