

TUSCAWILLA ANIMAL HOSPITAL

DROP OFF FORM

Date: _____

Dr: _____

Owner's Name: _____

Pet's Name: _____

Phone number(s) where a Doctor or Technician can reach you:

Reason for Drop Off:

Yes, I authorize x-rays, diagnostic tests, and/or laboratory tests at the discretion of the Doctor _____

No, I would like a call before any diagnostic tests are run _____

I AUTHORIZE TUSCAWILLA ANIMAL HOSPITAL TO TREAT MY ANIMAL AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE COST OF SAID TREATMENT.

X _____

OWNER/RESPONSIBLE PARTY'S SIGNATURE