TUSCAWILLA ANIMAL HOSPITAL
DROP OFF FORM

Date: _____ **Dr:** _____

Owner's Name: _____

Pet's Name: _____

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

_____

I would like to be contacted via text for updates at _____

Reason for Drop Off:

_____

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Yes, I authorize x-rays, ultrasound, 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.

WE REQUIRE A 50% DEPOSIT FOR CRITICAL / COMPLICATED MEDICAL OR SURGICAL CASES.

X_____

OWNER/RESPONSIBLE PARTY'S SIGNATURE