



Patient Drop-off/ Treatment Consent Form

Pet's Name: _____ Owner Name: _____

Primary Contact Number: _____

In case of an emergency and I cannot be reached, Please call:

Reason for visit/treatment:

Is your pet showing any of the following symptoms?

- Decreased Appetite
- Increased Appetite
- Itching/Scratching
- Vomiting
- Coughing
- Sneezing
- Lumps or Bumps
- Weight Loss
- Weight Gain
- Scooting
- Bath Breath
- Diarrhea
- Shaking Head
- Limping

Describe :

Is your pet currently on any medications?

- Yes
- No

If yes, Please list the medication and last dose:

May we sedate if necessary?

- Yes
- No

If deemed necessary, do you consent to:

- Blood Work
- Radiography
- Ultrasound

I verify I am the owner (or authorized agent for the owner) of the above named pet and authorize the above treatment(s) to be performed. I authorize the use of anesthesia and other medication as deemed necessary by the veterinarian and understand that hospital personnel will be employed in the procedure as directed by the veterinarian. I agree to be responsible for any charges incurred while my pet is in the care of Bensenville Animal Hospital, a treatment care plan has been provided to me, and I understand payment is due at the time my pet is discharged from the hospital. I understand that if my pet requires overnight round-the-clock specialty or emergency care, I may be referred to a 24 hour emergency veterinary hospital and my pet will require owner-provided transportation prior to the end of day at Bensenville Animal Hospital.

Owner Signature _____
Date