



Seven Hills Animal Hospital

Caring for Animals for 25 Years!

Phone: (434) 237-6631

Date of Admission _____

Admission Form

Owner's Name _____ Pet's Name _____ Pet's Age _____

- 🐾 Telephone Number where owner can be reached during the day _____
- **Note:** It is vital that we have a number where you may be reached immediately during the day that will not require us to leave a message for you to call us back.

🐾 Owners current address _____

Procedure(s) to be performed:

Spay Alter Declaw Dental Procedure Other _____

Dental Extraction Consent: If a Dental Procedure is being performed and tooth extractions are deemed necessary by the doctor, I understand that Seven Hills will attempt to reach me at the phone number provided above. However, if I cannot be reached, I hereby give permission for the extractions to be performed without my verbal consent. _____ **(Please initial)**

Important – Please Note the Following Information

- 🐾 Additional fees may apply if a pet is in heat at the time of a spay operation.
- 🐾 ALL PETS MUST BE UP-TO-DATE ON ANNUAL BOOSTERS AND RABIES VACCINATIONS, AND HAVE HAD A STOOL EXAM FOR PARASITES WITHIN THE PAST SIX MONTHS.
 - If not current, vaccinations and/or a stool exam will be updated upon admission to the hospital at the owner's expense
- 🐾 All pets being spayed or altered will routinely spend one night in the hospital.
- 🐾 Dental patients can generally go home the same day.
- 🐾 During their stay with us, pets will be cared for and closely monitored.

ADDITIONAL PROCEDURES AVAILABLE WHILE YOUR PET IS IN THE HOSPITAL

- Express Anal Sacs Teeth Cleaning (ultrasonic scaling & polishing) (Inquire for estimate of costs)
- Stool (Fecal) Examination HomeAgain Microchip implantation

PET HISTORY (Please read and fill out information below completely) (Check YES or NO below)

YES	NO	
_____	_____	Has your pet had vaccinations within the past year?
_____	_____	Is your pet on Heartworm Preventative?
_____	_____	Has your pet been tested for Feline Leukemia and/or AIDS viruses? (Cats only)
_____	_____	Has your pet been checked for intestinal parasites in the last 6 months?
_____	_____	Any recent problems with the following?
_____	_____	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Coughing <input type="checkbox"/> Sneezing <input type="checkbox"/> Listlessness <input type="checkbox"/> Runny Eyes <input type="checkbox"/> Runny Nose
_____	_____	Was your pet fasted overnight? When was your pet's last meal? _____
_____	_____	Is your pet ALLERGIC to any drugs or medications?
_____	_____	Any major medical problems?
_____	_____	Is your pet on a special diet?
_____	_____	Is your pet on any Medication? Last dose was given _____ Next dose is due _____
_____	_____	Is your pet's appetite and water intake normal?
_____	_____	Has your pet been urinating normally and having normal bowel movements?
_____	_____	Does your pet have a history of seizures?
_____	_____	Has your pet had any previous problems with anesthesia?

Comments or other problems/information _____

By signing below, I indicate that I have read and understand the information above:

OWNER/CARETAKER SIGNATURE _____ **DATE** ___/___/___