

Fall Creek
Veterinary Medical Center

**APPOINTMENT SCHEDULE
REQUEST FORM**

This form may be filled in and returned via e-mail or FAX'ed to us.

Your Name: _____

Your Pet's Name: _____

___ *Canine* ___ *Feline* ___ *Other:* _____

Have we seen this patient before? ___ *Yes* ___ *No* ___ *Unsure*

Nature of issue for appointment:

___ Routine/ Checkup/ Vaccinations
___ Illness/ Injury/ Problem. Please describe briefly: _____

___ Re-evaluation/ Progress Exam
___ Nail Trim/ Suture Removal/ Other Technician Services
___ Grooming/ Bathing

Desired Date: _____

Desired Time: ___ *AM* ___ *PM*
(Please see our posted office hours)

Best Contact: ___ *Phone:* (___) _____
 ___ *E-mail. Address:* _____

Additional Information: _____

We frequently check e-mail and FAX's, and our front desk staff will be in touch promptly. However, please allow one business day to respond in setting up your appointment. Same-day appointments are best scheduled by calling the office directly at 841.8900.

THANK YOU!

