Centreville Animal Hospital

New Client and Patient Form

Doctors: Fred Garrison · Rhonda Pierce · Sandra Pickard · Travis Taylor · Allison Hagner · Robin Jones · Sara Monahan

Client Information

Name Mr. Mrs. Ms. Dr. ______________________ DOB ____________ SSN________________

Address____ Apt # _______

City ___________________________ State _________________ Zip _________

Home # _______________________ Work # _________________ Cell# ________________

Employer_______________________ Address _______________________________________

Spouse Name Mr. Mrs. Ms. Dr. ________________ DOB ____________ SSN ________________

Home # _______________________ Work # _________________ Cell# ________________

E-Mail Address __________________________ Referred by ___________________________

Previous Veterinarian _____________________ City _________________ State ________

Please let the doctor know if any person living with these pets is immunocompromised.
We will help all of your family members.

Patient Information #1

Our pet is a: member of our family _____ child's pet _____ backyard pet _____ other _____

Name __________________________ Any previous serious illnesses or injuries? ___________

Species _________________________ ____

Breed __________________________ Any known allergies to vaccinations or medications?

Date of Birth _____________________ ____

Color __________________________ Where/When was your pet obtained? _______________

Sex: ☐ Male ☐ Female ____

☐ Neutered ☐ Spayed

Current Diet _________________________________

Last Known Weight________________ Amount ___________ # times per day __________

Financial Responsibility Agreement

Payment is required at the time services are rendered. I understand that, for any balance not paid in a timely fashion, I will be responsible not only for the balance due but any collection and/or reasonable attorney fees that are incurred in the attempt to collect this debt. Cash, Check, Visa, MasterCard, Discover, American Express, and Citi Health Card are accepted. We require a photo I.D. to cash checks for services and products.

Printed Name_________________ **Signature**_____________________ **Date** ___________

Patient Information #2

Our pet is a: member of our family _____ child's pet _____ backyard pet _____ other _____

Name ______________________________

Species ______________________________

Breed ______________________________

Date of Birth ________________________

Color ______________________________

Sex: ☐ Male ☐ Female

☐ Neutered ☐ Spayed

Last Known Weight __________________

Any previous serious illnesses or injuries? ____________

____

Any known allergies to vaccinations or medications?

____

Where/When was your pet obtained? ________________

____

Current Diet ______________________________________

Amount ____________ # times per day ___________

Patient Information #3

Our pet is a: member of our family _____ child's pet _____ backyard pet _____ other _____

Name ______________________________

Species ______________________________

Breed ______________________________

Date of Birth ________________________

Color ______________________________

Sex: ☐ Male ☐ Female

☐ Neutered ☐ Spayed

Last Known Weight __________________

Any previous serious illnesses or injuries? ____________

____

Any known allergies to vaccinations or medications?

____

Where/When was your pet obtained? ________________

____

Current Diet ______________________________________

Amount ____________ # times per day ___________

Centreville Animal Hospital

13663 Lee Highway Centreville, VA. 20121 703-830-1182 703-830-1217 (fax)

Commonwealth of Virginia Veterinary Disclosure Form

{Please read carefully before signing}

Centreville Animal Hospital has business and medical staffing hours as follows:

Day	Hours
Mondays	7:00 AM TO 6:30 PM
Tuesdays	7:00 AM TO 6:30 PM
Wednesdays	7:00 AM TO 6:30 PM
Thursdays	7:00 AM TO 6:30 PM
Fridays	7:00 AM TO 6:30 PM
Saturdays	8:00 AM TO 2:00 PM

Therefore, this is to inform you that we have no in-house, on-duty continuous medical staff care:

1. **Overnight, from closing time each weekday until opening the next day.**
2. **Weekends, from closing time on Saturday to opening time Monday morning at 7:00 am**
3. **Holidays that this also applies include:**

New Year's Day	Labor Day Monday
Memorial Day Monday	Thanksgiving
July 4th	Christmas Day

I have read this form and I am aware of the above staffing hours.

______________________________ ______________________________ ______________

Signature of Owner or Responsible Party **Printed Name** **Date**