North Oatlands Animal Hospital & Reproduction Center
19275 James Monroe Highway
Leesburg, Virginia 20175
(703) 777-7781 office (703) 777-2758 fax
www.NOAHVETS.com ~ info@NOAHVETS.com

Dominion Valley Animal Hospital
5371 Merchant's View Square
Haymarket, Virginia 20169
(703) 753-4444 office (703) 753-4446 fax
www.DVVETS.com ~ info@DVVETS.com

NEW CLIENT INFORMATION SHEET

Client Information:

Name _____ Spouse's Name _____

Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ Cell Phone _____ Email _____

Occupation _____ Employer _____ Work Phone _____

Spouse's Occupation _____ Employer _____ Work Phone _____

Emergency Contact _____ Emergency Phone _____

Who can we thank for referring you to our practice?

☐ Internet (Which Website?) _____ ☐ Phone Book (Circle One) Super Pages (Yellow) or Community Book (Red)

☐ Existing Client _____ (Referrers will receive $20.00 off their next visit!) ☐ Other _____

Patient Information:

Pet Name _____ Canine / Feline / Other _____ Sex M / F / MN / FS

Breed _____ Color _____ Date of Birth _____ Age _____

Microchip # _____ Tattoo # _____

Has this pet EVER bitten anyone, exhibited aggressive behavior or require special care while handling Yes / No

If Yes, Completely Explain _____

Please describe any/all Prior Medical Conditions and Dates of Procedures _____

_____

Previous Veterinary Clinic (if applicable): _____

By Signing below, I hereby attest that the information provided on this form and all other Patient Information forms is correct and complete to the best of my knowledge and understand that hospital patients may only be presented for services by the owner of record and/or an agent empowered in writing to authorize all treatments and remit payment(s). Further, I acknowledge that payment in full is due at the time services are rendered. I accept responsibility for any charges incurred in providing veterinary care to this/these patient(s) and understand in the event of an incomplete payment or non-payment, I will be charged a one-time late payment fee of $35. Additionally, accounts not paid within 30 days of the date of the invoice are subject to a 2.49% monthly finance charge with an associated processing fee of $5. In addition to the outstanding debt, I understand that I will be held liable and responsible for any and all charges related to collecting this debt including collection agency fees & charges which may equal the amount of the outstanding debt as well as applicable attorney's fees. I understand that I may and have been encouraged to request an estimate before services are rendered.

I understand that if I need to cancel a future appointment or scheduled procedure, I must provide 48hrs notice or a cancellation fee may be assessed in the amounts of $55.00 for an appointment or $175.00 for a procedure.

I understand that ALL veterinary records and radiographs (X-rays), physical as well as electronic, including Images, photographs, scans and reports are the property of North Oatlands Animal Hospital, PC. All non-emergency requests for copies of patient records must be made in writing and will be processed within 5 business days of receipt of request. A preparation fee of $25 will be charged for full medical record processing.

_____ _____

Signature Date