CLIENT / ANIMAL INFORMATION

(Last) (First) (M.I.)

Owner's Name: _____

(Last) (First) (M.I.)

Spouse's Name: _____

Address: _____

(City) (State) (Zip)

_____

Home Phone: _____ **SSN:** _____

Work Phone: _____ **Spouse's SSN:** _____

Contact Number: _____ **Employer:** _____

Spouse's Work Phone: _____ **Spouse's Employer:** _____

Email Address _____ **Client DOB** _____

I am the owner/agent for the owner of this animal(s) and have authority to execute this consent. I request/authorize that ANIMAL HEALTH CARE CENTER P.C., it's Veterinarians, agents & employees perform the services which are necessary to the examination & medical treatment of the animal(s) described and identified here. I understand that the treatment & examinations will be conducted in accordance with the prevailing standards of competency in Veterinary Medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by this center. I assume FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED TO THE PATIENT FOR SERVICES RENDERED AND UNDERSTAND THAT UPON EACH VISIT FULL PAYMENT IS EXPECTED UPON DISCHARGE OF THE PATIENT, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH MANAGEMENT.

I understand that if this balance is not paid in a timely fashion, that I will be responsible, not only for the balance due but any collection and for reasonable attorney fees that are incurred in the attempt to collect this debt.

MY METHOD OF PAYMENT WILL BE: _____ **CASH** _____ **CREDIT CARD**

Owner's or Agent's Signature _____ **Date** _____

****CONTINUED ON BACK****

Request for services * Authorization for Examination & Medical Treatment

****Financial Responsibility****

Animal's Name:_____ **Animal's Name:**_____
Breed:_____ **Weight:**____ **Breed:**_____ **Weight:**____
Color:_____ **Color:**_____
Sex:___ **Spayed:**____ **Neutered:**____ **Sex:**___ **Spayed:**____ **Neutered:**____
Birth date:_____ **Birth date:**_____

MEDICAL HISTORY

Vaccinations: Please give most recent dates:
Rabies (1)_____**(2)**_____ **Fe-Distemper (1)**_____**(2)**_____
Distemper-Parvo (1)_____**(2)**_____ **Fe-Leuk Test (1)**_____**(2)**_____
Heartworm Test (1)_____**(2)**_____ **Fe-Leuk Vacc (1)**_____**(2)**_____
Fecal (1)_____**(2)**_____ **Fe-Aids Test (1)**_____**(2)**_____
Bordetella _____**(2)**_____
***Is your dog or cat currently on any medication such as Heartworm Preventive?**___
If yes, name of medicine _____**. Is your animal experiencing any of the following: Hair loss**_____**, Bad Breath**_____**, Itching/Scratching or other Skin Irritations** _____ _____**, Breathing Problems** _____**, Weight Loss or Gain** _____ **Change in appetite** _____**, Other** _____ **Major Surgeries** ___ _____ **Other Concerns** _____
_____
_____

*****HOW DID YOU FIND OUT ABOUT ANIMAL HEALTH CARE CENTER P.C.?**

_____

If you found our about us through a family member or friend, would you please give us their name?

_____

ANIMAL HEALTH CARE CENTER P.C.

1935 ROSSER AVENUE
WAYNESBORO, VA 22980
PHONE: 540-943-CARE (2273)
FAX: 540-943-2276
AFTER HOURS EMERGENCIES: 540-248-1051 – VETERINARY EMERGENCY SERVICES, VERONA, VA or VETSS Emergency in Charlottesville 434-973-3519.

DR. HEATHER SMITH DR. JOHN DUNLAP
DR. KAYLA ECKARD DR. JAN MARION

Virginia Veterinary Disclosure Form

ANIMAL HEALTH CARE CENTER P.C. has business and medical staffing hours as follows: Monday – Friday 7:00 a.m. to 5:30 p.m.; Saturday 8:00 a.m. to 11:00 a.m. and Boarding pickup & drop off only on Sundays from 6:30 p.m. – 7:00 p.m.: closed on Holidays. The veterinarian and medical staff make periodic checks during the non-staffed hours, weeknights, weekends, Sundays and on Holidays as needed to assure our clients that their pets are well cared for.

Therefore, this is to inform you that we do not have in-house, on-duty, continuous medical staff care except as above.

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

Signature_____ **Date** _____