Client and Patient Information Sheet

PINE MEADOW VETERINARY HOSPITAL • EST. 1977 •

1403 George Washington Memorial Highway
Yorktown, Virginia 23693
(757) 599-3326
www.pinemeadowvet.com
frontdesk@pinemeadowvet.com

Thank you for giving Pine Meadow Veterinary Hospital the opportunity to care for your pet. So that we may become better acquainted, please complete the following:

Today's Date: _____

Owner(s): _____

Any Additional Authorized Guardians: _____

Address: _____

Phone Number	Home/Cell/Work	Who does it belong to?	Can it receive texts?
PRIMARY/PREFFERED			

Email Address: _____

Preferred method of contact: ☐ Phone ☐ Email ☐ Text Message _____

If you are new to our hospital, how did you become aware of us? ☐ Website ☐ Sign ☐ Facebook ☐ Google

☐ Friend or Family Referral: Whom may we thank for your visit? _____

Do you have pet insurance? If so, what type? _____

May we use photos of your pet(s) on our website, Facebook and Instagram accounts? ☐ Yes ☐ No

May we release your phone number, name and/or vaccine information to the Humane Society, County officials, or individuals that have identified your pet by a rabies vaccine tag or microchip and wish to contact you to return your pet? ☐ Yes ☐ No

Terms of Service

I assume full responsibility for all charges incurred and understand that a deposit may be required for hospitalization and/or treatment. I understand that Pine Meadow Veterinary Hospital does not extend credit out of the office, that ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICES RENDERED, and I agree to pay for these services. I understand that there is a minimum $20.00 service charge on all returned checks. Any unpaid accounts will be subject to a monthly interest charge of 2% and, should my account be assigned for collection, I will be responsible for all court costs and attorney's fee of thirty-three and one-third percent of all monies due.

I hereby authorize Pine Meadow Veterinary Hospital and its staff to examine, prescribe for, and/or treat my pet(s). All information I have provided here is true to the best of my knowledge. I have read and understand the Terms of Service.

Signature of Owner or Financially Responsible Party
(Must be 18 years or older) _____ **Today's Date**_____

We accept: Cash & Check / Debit Card / MasterCard / VISA / Discover / American Express / CareCredit

Patient Information

Please fill out the following for your pet(s) under our care:

Patient Name:

Species (Choose one): ◯ Dog ◯ Cat ◯ Other: ________________

Breed:

Gender (Choose one): ◯ Male ◯ Female ◯ Neutered Male ◯ Spayed Female

Color/Markings: Date of Birth:

Known Allergies:

Important Medical Issues:

Patient Name:

Species (Choose one): ◯ Dog ◯ Cat ◯ Other: ________________

Breed:

Gender (Choose one): ◯ Male ◯ Female ◯ Neutered Male ◯ Spayed Female

Color/Markings: Date of Birth:

Known Allergies:

Important Medical Issues:

Patient Name:

Species (Choose one): ◯ Dog ◯ Cat ◯ Other: ________________

Breed:

Gender (Choose one): ◯ Male ◯ Female ◯ Neutered Male ◯ Spayed Female

Color/Markings: Date of Birth:

Known Allergies:

Important Medical Issues:

Patient Name:

Species (Choose one): ◯ Dog ◯ Cat ◯ Other: ________________

Breed:

Gender (Choose one): ◯ Male ◯ Female ◯ Neutered Male ◯ Spayed Female

Color/Markings: Date of Birth:

Known Allergies:

Important Medical Issues: