



**North Oatlands  
Animal Hospital  
& Reproduction Center**

19275 James Monroe Hwy. Leesburg, VA 20175  
703-777-7781 • noahvets.com



**Dominion Valley  
Animal Hospital**

5371 Merchants View Sq Haymarket, VA 20169  
(703) 753-4444 • dominionvalleyvets.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  Super Pages (Yellow)  Community Book (Red)  
 Existing Client \_\_\_\_\_ (Referrers will receive \$20.00 off their next visit!)  
 Other \_\_\_\_\_

On occasion we may take a photo of your pet for educational or social media use, please check here if you do **NOT** want photos of your pet(s) used

### 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 \$50.00 for an appointment or \$150.00 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 \_\_\_\_\_