



{CLINICNAME}
 {CLINICADDRESS1} {CLINICADDRESS2}
 {CLINICCITY}, {CLINICSTATE} {CLINICPOSTALCODE}
 {CLINICPHONE}

{CURRENTDATE[SHORT]}

NAME: {FULLNAME}	CO-OWNER NAME:
EMPLOYMENT: PHONE: EXT:	EMPLOYMENT: PHONE: EXT:
SOCIAL SECURITY:(MUST HAVE FOR CHECKS)	SOCIAL SECURITY:
Birthdate:	
CELL OR HOME PHONE:	CELL OR HOME PHONE:
EMAIL:	EMAIL:

ADDRESS:

STREET: {ADDRESS1} {POSTALCODE}	CITY: {CITY}	STATE: {STATE}	ZIP:
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PETS NAME: {NAME}	PETS NAME:
BREED: {BREED}	BREED:
DATE OF BIRTH / AGE: {BIRTHDATE[SHORT]}	DATE OF BIRTH / AGE:
COLOR/MARKINGS: {MARKINGS} {COLOR}	COLOR/MARKINGS:
SEX: {SEX}	SEX: SPAYED/NEUTERED:
SPAYED/NEUTERED:	

TYPE:	DATE:	TYPE:	DATE:
RABIES: 1 YEAR 3 YEAR		RABIES: 1 YEAR 3 YEAR	
K-9 BORDETELLA		K-9 BORDETELLA:	
K-9 DA2PP OR DA2PLP		K-9 DA2PP OR DA2PLP:	
CORONAVIRUS		CORONAVIRUS:	
HEARTWORM TEST / RESULTS:		HEARTWORM TEST / RESULTS:	
FECAL / RESULTS:		FECAL / RESULTS	
FELINE FELV (LEUKEMIA)		FELINE FELV (LEUKEMIA)	
FELINE FVRCP		FELINE FVRCP:	
FELINE FIV/FELV TEST / RESULTS:		FELINE FIV/FELV TEST / RESULTS	

Due to operational costs we have established the following policy of PAYMENT IN FULL at the time services are rendered. we accept VISA, MASTERCARD, DISCOVER, AMEX, CARE CREDIT, PERSONAL CHECK, or CASH. A 50% deposit is required with all major hospital or surgical cases. In case of non-payment the owner is responsible for all collection fees. On all returned checks there is a \$30.00 returned check fee added to the balance.

I HEREBY UNDERSTAND AND AGREE TO THE AFOREMENTIONED PAYMENT POLICY
OF THE BON AIR ANIMAL HOSPITAL.

I UNDERSTAND THAT I AM LIABLE FOR ANY COSTS ASSOCIATED WITH THE CARE OR TREATMENT OF ANY ANIMAL, PERSONAL PET OR OTHERWISE, BROUGHT INTO THE CLINIC FOR EVALUATION AND/OR TREATMENT.

Date: _____

Signature: _____



{CLINICNAME}
{CLINICADDRESS1} {CLINICADDRESS2}
{CLINICCITY} {CLINICSTATE} {CLINICPOSTALCODE}
{CLINICPHONE}

STATE OF VIRGINIA CLIENT DISCLOSURE FORM

The Bon Air Animal Hospital is open from 8 AM to 7 PM Monday through Friday and Saturdays 9 AM to 12 PM. Doctor's hours are from 9 AM-6 PM Monday through Friday and Saturdays 9 AM-12 PM. This is to inform you that medical personnel are on duty during these hours only. NO IN-HOUSE, NO ON-DUTY, CONTINUOUS MEDICAL CARE IS AVAILABLE EXCEPT FOR THE ABOVE STATED HOURS.

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

Signature:	Date:
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