Client Registration

Client Name: ____
Last First Middle

Address: ____
Street City State Zip

Home Telephone: (_______) ______________Work Telephone: (_______) ___________________

Cell phone: (_______) ______________ Employer: ______________________________

Employer's
Address: ____
Street City State Zip

Drivers License Number: _____________________________ Date of Birth: _________________

E-Mail Address: ____
If you would like to receive reminders by E-mail please supply your address.

Spouse/Partner's Name: ____
Last First Middle

Address: ____
Street City State Zip

Home Telephone: (_____) ________________ Work Telephone: (_____) _____________________

Cell phone (_______________________ Spouse's Employer: _____________________

Employer's
Address: ____
Street City State Zip

Drivers License Number: _____________________________ Date of Birth: _________________

Spouse's E-Mail Address: ____
If you would like to receive reminders by E-mail please supply your address.

Person to contact in case of emergency (third party):_____________________________________

Address: ____
Street City State Zip

Home Telephone: (____) ________________ Work Telephone: (____) ______________________

Cell phone or Beeper: (____) ______________________

Name of person or source that referred you: ____

PAYMENT POLICY FOR SERVICES RENDERED

For your convenience, we accept cash, checks, Visa, Master Card, Discover, American Express and debit cards. We will be happy to discuss any fees with you before your appointment or give you an estimate at any time for services. It is our policy to charge $25.00 for any returned checks. There will be a finance charge applied to all accounts unpaid after 30 days. Finance charge is computed by a periodic rate of 1.50% per month, which is the annual percentage rate of 18.00%. There is a minimum finance charge of $9.00 per month.

FINANCIAL RESPONSIBILITY AGREEMENT

I, the undersigned, understand and acknowledge that if an account balance is not paid in a timely fashion, I will be responsible not only for the balance due but any collection, reasonable attorney fees, and /or court costs that are incurred in the collection process. I understand that Great Falls Veterinary Clinic Inc. reserves the right to add an additional twenty-five to fifty percent fee if my account is sent to outside credit collections and that the Great Falls Veterinary Clinic Inc. will report delinquent accounts to all credit reporting agencies.

I have read the Payment Policy and the Financial Responsibility Agreement and understand its contents.

Date: _______________ Client Signature: ____

VIRGINIA VETERINARY DISCLOSURE

Great Falls Animal Hospital has business and medical staffing hours as follows: Monday through Friday 7 AM to 8 PM, Saturday 8 AM to 3 PM, and is closed Sunday's and Holidays.

Therefore, this is to inform you, that we have no in-house, on-duty continuous medical staff care (although staff do come in between 10-11 pm to check patients): **(1) Overnight**, from closing time at 8 PM to opening time at 7 AM; **(2) Weekends**, from closing time Saturday at 3 PM to opening time Monday morning at 7 AM; **(3) Holidays**, from closing time before the holiday at 8 PM to opening time the day after the holiday at 7 AM **(4) Holidays** falling on Monday, from closing time Saturday at 3 PM to opening time on Tuesday at 7 AM; The doctors and staff members do come in to medicate, feed, and care for your pets during weekends and holidays.

*Please note that hospital is not responsible for any personal items left with patients (towels, bedding, toys, etc.).

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

Date: _________________ Client Signature: ____

Client ID #: _____________ Witness: ____

Patient Registration

CANINE/FELINE

Pet's name: ______________________________ Breed: __________________________________

Microchip or Tattoo Number: ____

Date born: ______________________________ Color: ____________________ Sex: _____________
Spay/Neuter

History of any previous surgery, treatments, or medications: ____
____

Name of Previous Veterinarian: ____
Address or Phone Number with Area Code, if possible

Dates of Last Vaccinations:

Canine:
Distemper – Hepatitis – Parinfluenza – Parvo
Vaccine: _____________1 – year or 3 – year
Leptospirosis: __________________________
Bordetella: ____________________________
Rabies: ______________ 1 – year or 3 – year
Fecal Exam: ___________________________
Last Heartworm Check: _________________

Feline:
Feline Distemper/ Upper Respiratory
Vaccine: __________1 – year or 3 – year
Feline Leukemia Test: _______________
Feline Leukemia: ___________________
Rabies: ___________ 1 – year or 3 - year
Fecal Exam: _______________________

AVIAN

Pet's name:________________ Type:________________ Age______ Sex, if known_______ Color __________
Wild caught / captive bred? Handraised? Yes / No Only bird / housed with others? Yes / No
Any quarantine period? Yes / No if so, how long?______ Bought from________ Owned how long?_________
Kept indoors / outdoors? If indoor, which room of house? _____ Approx. cage size?_______________
Type of bedding used?_____________ Cleaning agents used?__________________ Diet:_________________________
____ Treats? ____
Any vitamins or minerals added to food or water? Yes / No if so, what?_________________
Does the bird get a "bath"? Yes / No if so, _______ times / week Any playtime outside of cage? Yes / No
if so, how often? __________________________ Is playtime supervised? Yes / No
Ever been seen by vet before? Yes / No if so, where?____
Ever been ill before? Yes / No if so, for what?____
Ever been vaccinated? Yes / No if so, with what?___________________ Last vaccine date?___________
Any history of feather picking? Yes / No Any abnormal feather growth? Yes / No
Last general molt?________________ Other?____

If your pet is hospitalized, we will make attempts to reach you at the phone numbers you provide on treatment day. If we are unable to make contact with you, do you authorize any necessary treatments?

Yes **No** Please circle one

* Please see other side for Small Mammals & Reptiles *

SMALL MAMMALS

Pet's name: _________________ Species________________ Age_______ Sex, if known______ Color _________
Housed alone or with others?__________ Any exposure to other animals? Yes / No If so, what?_________
Any quarantine period? Yes / No if so, how long?_______ Bought from?__________________
Owned how long?________ Kept indoors / outdoors? Type of cage?______________ Approx. cage size?___________
Type of bedding used?_____________ Cleaning agents used?__________ Diet:_______________________________
____ Treats?___________________________________
Any vitamins or minerals added to food or water Yes / No if so, what?________________________________
Any playtime outside of cage? Yes / No if so, how long per day?_____________________________________
Is playtime supervised? Yes / No ____
Ever been seen by vet before? Yes / No if so, where?____
Ever been ill before? Yes / No if so, for what?____
Ever been vaccinated? Yes / No if so, with what?_____________ Last vaccine date?____________
Other?____

REPTILES

Pet's name: _________________ Species____________ Type: _________ Age_______ Sex, if known______
Wild caught / captive bred? Housed alone / or with others? If so, what?_________________
Any quarantine period? Yes / No if so, how long?_________ Owned how long?_________ Bought from?__________
Kept indoors / outdoors? Type of cage__________________ Approx. size of cage?________________
Type of bedding used?______________________ Cleaning agents used?_______________
How many hours of light daily?________ Do you use a full spectrum (UVB) light? Yes / No
Last time light was changed?______________
Type of heat source used?____________ Temp on warm side?__________ Temp on cool side?_______
Diet____
____ if fed rodents are they live / dead / or stunned?
Fed how often?____________ Any vitamins or minerals added to food? Yes / No if so, what?____________
how often added to food?______________ Water bowl kept in cage? Yes / No if so, how big?___________
Is cage misted? Yes / No if so, how many times per day / week?_____________
Ever been seen by vet before? Yes / No if so, for what?_____________________________
Ever been ill before? Yes / No if so, for what?_____________________________________
Last shed?___________________________ was it a complete shed? Yes / No
Other?____

If your pet is hospitalized, we will make attempts to reach you at the phone numbers you provide on treatment day. If we are unable to make contact with you, do you authorize any necessary treatments?

Yes **No** Please circle one

* Please see other side for Cats, Dogs & Avians *