WELCOME

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank you!

REGISTRATION

Date: ____________________ E-Mail address:______________________

Owner: ____

Address: ____ City:________________________

State:__________ Zip:___________

Home/Cell Ph: ________________ Work Ph: _______________Spouse Ph: _________________

How did you learn of our clinic? ____

If recommended, by whom? ____

Pet Health History

Name of Pet:____________________________ Cat / Dog / Other:_____________________

Breed:_________________________________ Color:______________________________

Birthdate:______________________________ Sex:__________ Neutered: Yes / No

Previous Vet where your records may be obtained:____________________________________

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charged incurred in the care of this animal. We will gladly prepare a written estimate if you desire (please ask our doctor or receptionist.) This will be important to you since **ALL PROFESSIONAL FEES ARE DUE AT THE TIME THE SERVICES ARE RENDERED**. In case of extensive medical or surgical procedures, when full payment may be difficult at discharge we take Master Card, Visa, Discover, American Express or can establish a payment arrangement if approved in ADVANCE of treatment.

Signature of owner:_____________________________________ Date:_________________

Method of Payment: Cash / Debit / Visa / Mastercard / Discover / American Express

Crossroads Animal Care Center

ANIMAL MEDICAL CARE DISCLOSURE

As Required by Article 54.1-306.1 of the Code of Virginia and enacted by the General Assembly July 1, 1998, we ask that you review the following information:

- **The hospital is open during the hours of 7:30 AM to 7:00 PM Monday through Friday and 7:30 AM to 12 noon on Saturday.**
- **There are no staff members present on a continuous basis when the hospital is closed.**

Please indicate, by your signature, that you understand the information outlined in this disclosure.

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Signature **Date**