

Church Hill Animal Hospital
322 N. 25th Street
Richmond, Virginia 23223
(804) 644-8200

VIRGINIA VETERINARY DISCLOSURE FORM
(Please read carefully before signing)

Church Hill Animal Hospital is a full-service veterinary medical and surgical facility. We are open for business as follows:

Monday through Friday: 7:30 am to 5:00 pm

Weekends and major holidays: closed

Therefore this disclosure form is provided to inform you that we have no in-house, on-duty continuous medical staff care as follows:

- 1.) Overnight, from closing time at 5:00 pm to opening at 7:30 am.
- 2.) Weekends, from closing on Friday at 5:00pm to opening on Monday at 7:30 am.
- 3.) Holidays, from closing time before the holiday at 5:00 pm to opening time the day after the holiday at 7:30 am.
- 4.) Holidays falling on Monday, from closing time Friday at 5:00p to opening time on Tuesday at 7:30 am.

If you have questions concerning this policy, please don't hesitate to ask. Also if you would like to have continuous overnight care of your pet, discuss those options with the doctor.

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

Signature of Responsible Party

Date

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Patient/Client Information

Thank you for choosing **Church Hill Animal Hospital**. We look forward to providing care for your animal companion. Please help us get to know you and your companion by completing the following information.

Date _____

(Please circle one) Mr. / Mrs. / Ms. / Dr.

Owner's Name _____ Spouse/Other/ Partner _____

Address _____ Apt/Unit Number: _____

City _____ State _____ Zip _____

Home Telephone _____ Work Phone _____

Cell Phone: _____ Spouse/Other's Cell Phone: _____

Spouse's/Other's Work Telephone _____ email* _____

Employer's Name _____

Spouse's/Other's Employer _____

*Please provide your email address as we are trying to "go green" and will be emailing reminders. Please do NOT put your email address if you do not wish to receive electronic reminders.

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. We will gladly prepare a written estimate if requested. We accept Master Card, Visa, cash and checks with ID. Returned checks will acquire a \$35.00 processing fee. In the event this account is turned over for collection, the owner/agent is responsible for fees in the amount of 33 1/3% of the outstanding balance.

Signature of client responsible for pet(s): _____ Date: _____

How did you hear about our hospital? (please check all that apply)

Phone book _____ Location _____ Referral _____

Hospital Sign _____ Advertisement _____ Other _____

Individual: someone we may thank? _____

Animal Medical History (please complete all information for each animal)

Name _____ Species (cat, dog, other) _____

Breed _____ Color _____

For non-pedigreed **cats** please check one: Short Hair _____ Medium Hair _____ Long Hair _____

Age (years) _____ Date of Birth _____

Sex (please check one): Male _____ Female _____ Neutered Male _____ Spayed Female _____

Is your pet on any medications? _____ If yes, please list ALL medications your pet is currently taking, including heartworm preventative and flea medications:

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