

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

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 primarily utilizing email and text for 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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