538 E. Constance Rd.
Suffolk, Va 23434
(757)925-2011

WELCOME - New Client Information Sheet

Name: _____ Date:_____

Address: _____ City:_____ State:_____

Zip Code:_____House Phone:_____ Cell Phone:_____

Which would be a primary number? **(Circle One)** Home Cell

Driver's License # _____ Email: _____

Please choose a preferred method of contact: (Circle one) Text Email Phone

Spouse/ Significant Other: _____

Phone(s):_____ Email: _____

Place of Employment:_____ Phone:_____

Emergency contact: _____Phone:_____

How did you hear about our clinic? Previous Client_____Friend_____Internet_____Location_____
Personal Recommendation (Whom may we thank?)_____ Other_____

****We do not bill. All fees are due at the time that services are rendered.****
We accept Care Credit, Visa, MasterCard, Discover, and American Express as well as cash and personal checks.

I give permission for photos and videos of my pet to be used in all forms of social media, including Facebook, YouTube and Twitter. _____ YES _____ NO

I certify that I am the person responsible for authorizing and paying for all medical procedures and expenses for the listed pet(s).

Signature:_____ Date:_____

PLEASE FILL OUT INFORMATION ABOUT YOUR PET BELOW:

Name:_____ Species: Dog Cat Age/ Date of Birth:_____

Breed:_____ Color:_____ Sex: M / F Spayed/ Neuter? Y / N

Medical History/ Chronic Illnesses:_____

Name:_____ Species: Dog Cat Age/ Date of Birth:_____

Breed:_____ Color:_____ Sex: M / F Spayed/ Neuter? Y / N

Medical History/ Chronic Illnesses:_____

Owner Name: _____ Pet Name:_____

Please circle your preferred method of contact: Text Email Phone Mail

Preferred Doctor (if applicable): _____

Please list the names of all individuals (other than you) who are authorized to **make medical decisions** for your pet (please note the individual must be older than 18 years of age).

_____
_____
_____
_____
_____
_____
_____
_____

Please list the names of any **individuals/companies** who you authorize having access to your pet's medical records (*insurance companies, groomer, boarding facility, rescues, etc*) and indicate if they are allowed access to the full medical record (often needed by insurance companies) or just the vaccine records.

_____	Full Medical Record	Vaccines Only
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_____	Full Medical Record	Vaccines Only
_____	Full Medical Record	Vaccines Only
_____	Full Medical Record	Vaccines Only
_____	Full Medical Record	Vaccines Only

Finally, please indicate whether or not you allow us to release your records to **other veterinarians** should they call and ask for records (*emergency hospitals, referral hospitals, second opinions, other general practitioners, etc*). Please initial your preference below:

_____ I allow release of my medical records to other Veterinary Offices should they call and ask for records.

_____ I do not allow release of my medical records to other Veterinary Offices unless my consent is obtained immediately following each request.

In the event that any of these preferences or authorizations change, please notify us immediately so that we can update our records.

_____ _____

(Signature) (Date)

Tidewater Animal Clinic

538 E. Constance Road Suffolk, VA 23434

Virginia Law requires us to provide you with this form, which details when continuous medical care is not available at this office.

The office is staffed from 8:00 AM – 6:00 PM Monday, Wednesday, and Friday, from 8:00 AM – 7:00 PM Tuesday and Thursday, and from 8:00 AM – 12:00 PM Saturday. Continuous medical care is not provided from 6:00PM – 8:00 AM Monday, Wednesday, Friday, from 7:00PM – 8:00AM Tuesday and Thursday, and from 12:00pm Saturday to 8:00AM Monday.

The office is closed Sundays and major holidays. After hours care and treatment is at the discretion of the veterinarian.

Signature: _____ Date: _____