ANIMAL VISION CENTER *of* VIRGINIA

Phone (757) 749-4838
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AnimalVisionCenterVA.com
521 Old Great Neck Road, Suite 2
Virginia Beach, VA 23454

So they can see a better life.

Client / Patient Admission Form

1. CLIENT INFORMATION

Owner's Name: _____ **Co-Owner's Name:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____ ☐ *Check box if you would **NOT** like to receive emails from Animal Vision Center of VA*

Employer: _____ **Preferred Method of Contact:** ☐ Phone ☐ Text ☐ Email

Veterinary Practice: _____ **Veterinarian:** _____

2. PATIENT INFORMATION

Pet's Name: _____ **Date of Birth/Age:** _____

Breed: _____ **Color:** _____

Species: ☐ Canine ☐ Feline ☐ Other: _____

Sex: ☐ Intact Male ☐ Neutered Male ☐ Intact Female ☐ Spayed Female

Reason for Visit: _____

3. AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat my pet(s). I will assume all financial responsibility for any and all charges incurred by my pet(s) while in the care of the doctors at Animal Vision Center of Virginia. I understand that these charges will be paid at the time services are rendered and that a deposit may be required prior to treatment.

Animal Vision Center of Virginia accepts cash, VISA, MaserCard, American Express, Discover, Credit Care, and personal check. If paying by check, please provide the following information:

Driver's License #: _____ **State:** _____ **Date of Birth:** _____

_____ *[Client Initials]*

If I have to cancel my appointment with less than 24-hour notice, or do not show up for my scheduled appointment, I understand that I will be charged a $40 cancellation fee to be paid prior to rescheduling this appointment or refilling previously prescribed medications

☐ *Check box if you would **NOT** like your pet's picture to be featured in social media*

Client Signature: _____ **Date:** _____