OLD DOMINION ANIMAL CLINIC
4640 Chester Square Rd
Chester, VA 23831
Phone: 804-796-3647
Fax: 804-796-3682

In an effort to save time at your first visit, please have your pet(s) records with you or faxed to us ahead of your scheduled appointment.

Client Information

First Name________________________ Last Name________________________

Address____

City______________________ State__________ Zip______________

Home Phone (____)__________ Cell Phone (____)__________ Work Phone (____)__________

Drivers License Number____

E-mail Address____

Employer____

Employer Phone Number (____)__________________________________

Employer Address____

Whom may we thank for referring you?____________________________

Pet Information

Pet #1: Pet's Name__________________ ☐Dog ☐Cat ☐Other__________________

☐Male ☐Neutered / ☐Female ☐Spayed Breed__________________ Color__________

Birthdate/Age__________________ Known Allergies/Health Problems__________________

Pet #2: Pet's Name__________________ ☐Dog ☐Cat ☐Other__________________

☐Male ☐Neutered / ☐Female ☐Spayed Breed__________________ Color__________

Birthdate/Age__________________ Known Allergies/Health Problems__________________

Pet #3: Pet's Name__________________ ☐Dog ☐Cat ☐Other__________________

☐Male ☐Neutered / ☐Female ☐Spayed Breed__________________ Color__________

Birthdate/Age__________________ Known Allergies/Health Problems__________________

Pet #4: Pet's Name__________________ ☐Dog ☐Cat ☐Other__________________

☐Male ☐Neutered / ☐Female ☐Spayed Breed__________________ Color__________

Birthdate/Age__________________ Known Allergies/Health Problems__________________

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Phone(804)-796-3647 Fax(804)-796-3682
ODAC@comcast.net

Virginia Veterinary Disclosure Form

Please read carefully before signing

Old Dominion Animal Clinic is a full service veterinary medical facility. We have Business and medical staffing hours as follows: Monday and Friday 7:00 am – 6:30 pm, Tuesday and Thursday 7:00am-7:00pm, Wednesday 7:00am –6:00pm, and Saturday 8:00am – 1:00pm. We are closed Sundays and holidays.
Therefore, this is to inform you that medical personnel are on duty during these hours only. No in-house, on duty, continuous medical care is available except for the above stated hours.

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

Signed: ______________________ Date______________

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Payment

(Please read carefully before signing)

We routinely prepare a written estimate. ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. In cases of extensive medical or surgical procedures where full payment may be difficulty at discharge we accept MasterCard, Visa, Discover, and CareCredit. There will be a service charge of $35.00 for any check returned unpaid. To prevent the spread of infectious diseases, all hospitalized patients must be current on ALL VACCINATIONS AND FREE FROM INTERNAL AND EXTERNAL PARASITES. The signature below authorizes this level of preventative care and the appropriate charges will be assessed in the invoice.

Signed:____________________________ **Date:**________________