Phone: 1 (757) 497-8492
Fax: (757) 497-6054

BOSTIC VETERINARY HOSPITAL,INC

5269 CHALLEDON DRIVE
VIRGINIA BEACH, VA
23462

Home Phone ______________

Owner's Name ______________________ Soc. Sec. # ______________
first middle last

Home Address ______________________ City ______________ Zip ______________

Employer's Name ______________ Address ______________ Work Phone ______________

Spouse's Name ______________________ Spouse's Soc. Sec. # ______________
first middle last

Spouse's Employer ______________ Address ______________ Work Phone ______________

Referred By ______________________

How did you become aware of our clinic: ☐ **Hospital Sign** ☐ **Yellow pages** ☐ **Vet Locator** ☐ **WebSite**

☐ Other, please specify ______________________

☐ Individual (someone we may thank) ______________ ______________

Pager # ______________ Mobile Phone ______________ E-mail ______________

What time is it best to call about your pet? ______________ and at what Phone# ? ______________

In case of EMERGENCY, call ______________ **at phone#** ______________

Animal Information

Name ______________________ Sex M F S(spayed) N(neutered) Weight ______________

Canine (06) ____ Feline (10) ____ Other ______ Breed ______ Color/Markings______ Date of Birth ______

Place of Last Immunization: ______________________ Phone # ______________

Date of Last Immunization:

Canine-- DHLPPC ________ HW Check ________ Lyme ________ Bord ________ Rabies________

Feline-- FDRCVC ________ Leukemia ________ Leuk Test ________ Rabies ________

ALL FEES ARE DUE AND PAYABLE UPON COMPLETION OF SERVICES

Method of payment: ☐ Cash ☐ Check ☐ Credit Card Number

REQUEST FOR SERVICES-AUTHORIZATION FOR EXAMINATION AND MEDICAL TREATMENT

I am the owner or agent for the owner of the animal(s) described below and have authority to execute this document.

I request that the Bostic Veterinary Hospital, its veterinarians, agents and employees perform the services which are necessary to the examination and medical treatment of the animals described in this file.

I authorize the veterinarians on duty (and assistants they may designate) to examine the animal(s) and to administer medical or emergency surgical treatment which is considered therapeutically and/or diagnostically necessary on the basis of the findings during the course of examinations. Therefore, I hereby consent to and authorize the performance of such procedure(s) as are necessary and desirable in the exercise of the veterinarian's professional judgement.

I further understand that any animal found to be infected with either external (fleas or ticks) or internal (worms) parasites will be treated for same at my expense.

I understand that the treatment of the patient will be conducted with due care and in accordance with the prevailing standards of competency in veterinary medicine. I certify that no guarantee or assurance has been made as the results that may be obtained through the course of treatment undertaken by the Bostic Veterinary Hospital, its veterinarians, agents or employees.

I also consent to the release of medical information.

FINANCIAL RESPONSIBILITY

I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES TO THE PATIENT FOR SERVICES RENDERED AND UNDERSTAND THAT FULL PAYMENT IS REQUIRED UPON DISCHARGE. ANY CHARGES NOT PAID IN 30 DAYS WILL HAVE FINANCE CHARGES OF 1 1/2% PER MONTH (18% ANNUAL) ADDED. ANY ACCOUNT REQUIRING LEGAL ACTION WILL HAVE LEGAL FEES OF 33 1/3% AND ALL COURT COSTS ADDED TO THE ACCOUNT. AN ESTIMATE OF CHARGES IS AVAILABLE WITHIN A RESONABLE TIME AT MY REQUEST.

X Signature of Owner or Agent ______________________ Date ______________