Bon Air Animal Hospital

2749 McRae Road
Richmond, VA 23235
(804) 320-5991

NAME:	**CO-OWNER NAME:**
EMPLOYMENT: **PHONE:** **EXT:**	**EMPLOYMENT:** **PHONE:** **EXT:**
SOCIAL SECURITY:(MUST HAVE FOR CHECKS)	**SOCIAL SECURITY:**
Client's Birthdate:	
CELL OR HOME PHONE:	**CELL OR HOME PHONE:**
EMAIL:	**EMAIL:**

ADDRESS:

STREET:	**CITY:**	**STATE:**	**ZIP:**

PETS NAME:	**PETS NAME:**
BREED:	**BREED:**
DATE OF BIRTH / AGE:	**DATE OF BIRTH / AGE:**
COLOR/MARKINGS:	**COLOR/MARKINGS:**
SEX: **SPAYED/NEUTERED:**	**SEX:** **SPAYED/NEUTERED:**

Patient Veterinary History:
Has your pet been to the vet before?_____
If so, what is the name of the Veterinarian/Practice(s)?: _____
Do you have copies of their records with you? _____
If not, please call your previous vet and have all records emailed or faxed to us prior to your appointment:
Our Email Address: info@bonairanimalhospital.com **Our Fax Number: (804) 320-3517**

Due to operational costs we have established the following policy of PAYMENT IN FULL at the time services are rendered. we accept VISA, MASTERCARD, DISCOVER, AMEX, CARE CREDIT, PERSONAL CHECK, or CASH. A 50% deposit is required with all major hospital or surgical cases. In case of non-payment the owner is responsible for all collection fees. On all returned checks there is a $30.00 returned check fee added to the balance. Appointments must be canceled within 24hrs prior to the scheduled appointment. In the event of a no show, you will be required to pre-pay for your pets exam going forward.

I HEREBY UNDERSTAND AND AGREE TO THE AFOREMENTIONED PAYMENT POLICY OF THE BON AIR ANIMAL HOSPITAL.

I UNDERSTAND THAT I AM LIABLE FOR ANY COSTS ASSOCIATED WITH THE CARE OR TREATMENT OF ANY ANIMAL, PERSONAL PET OR OTHERWISE, BROUGHT INTO THE CLINIC FOR EVALUATION AND/OR TREATMENT.

Signature: _____ Date: _____

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STATE OF VIRGINIA CLIENT DICLOSURE FORM

The Bon Air Animal Hospital is open from 8 AM to 7 PM Monday through Friday and Saturdays 9 AM to 12 PM. **Doctor's hours are from 9 AM-6 PM Monday through Friday and Saturdays 9 AM-12 PM.** This is to inform you that medical personnel are on duty during these hours only. NO IN-HOUSE, NO ON-DUTY, CONTINOUS MEDICAL CARE IS AVAILABLE EXCEPT FOR THE ABOVE STATED HOURS.

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

Signature:	Date: