**Animal Medical Center of Frederick County, PC**
P.O. Box 1117, 681 Aylor Road, Stephens City, VA 22655
Office 540-868-1001, Fax 540-868-1011

**New Patient and Client Information Sheet**

Thank you for the opportunity to care for your pet.
So that we may be better able to meet your needs, please complete the following:

Title _____ First Name _____ Last Name _____

Address _____ City _____

State _____ Zip Code _____ Spouse Name _____

If above is a P.O. Box, please give physical address in addition:

_____

Email Address_____ (to receive email reminders for your pet(s).)

Social Security or Drivers License Number _____(for check writing purposes)

Home Phone (_____)_____ Cell Phone (_____)_____

Spouse Phone (_____)_____

Place of Employment _____ Work Phone (_____)_____

**How did you become aware of our hospital?** Drove By [ ] Yellow Pages [ ] Other [ ]

Previous or Current Client [ ] Referral from another vet [ ]

Whom may we thank? _____

**Patient Information**

Pet's Name _____ Sex _____ Neutered or Spayed? _____

Age_____ Canine or Feline _____ Breed _____ Color _____

**Payment Policy:**

All fees are due when services are rendered. The hospital accepts American Express, Visa, MasterCard, Discover and Care Credit in addition to cash and checks. Deposits may be required for major medical/surgical cases, or trauma and emergency work where hospitalization is required. All services must be paid in full before the animal can be released.

I will be responsible for all collection, returned check, court and/or attorney fees (33.3%), which may occur in the collection of this account if I default on this payment agreement. I also understand that interest charges of 2% per month (24% annually) and a $2.00 service charge will be applied to balances over 30 days. I certify that I am at least 18 years of age, authorized and duly capable to verify information about this patient and authorize treatment of this patient.

**Cancellation Policy:**

Our hospital policy asks that you give us a 24-hour notice before canceling appointments. By not giving us sufficient notice, it hinders our ability to see other patients that may need medical care. Your account will be charged an appropriate office fee if this should occur.

_____ _____
Signature of owner or responsible agent Date

Emergency Contact _____ Phone (_____)_____