3311 MECHANICSVILLE TPK
RICHMOND VA 23223

FARMERS VETERINARY HOSPITAL
QUALITY PET CARE
SINCE 1929

TEL (804) 329-5553 FAX (804) 228-8301
FARMERSVETHOSP@GMAIL.COM

www.farmersvet.com

NEW CLIENT INTAKE FORM

Today's Date:_____/_____/_____

Owner/Caregiver: Mrs.☐ Mr ☐ Ms ☐ Dr. ☐

First Name:_____MI:_____Last Name:_____

Home Address:_____

City:_____State:_____ZIP:_____

Home Phone:_____Work:_____Cell:_____

Email Address:_____

Driver's License or I.D. Card Number:_____Expiration Date:_____

Partner/Spouse/Co-Owner: Mrs.☐ Mr.☐ Ms.☐ Dr.☐

First Name:_____MI:_____Last Name:_____

Phone:_____Email Address:_____

How did you hear about us?

❑ Drive-By ❑ Yelp ❑ Google ❑ Facebook

❑ Personal recommendation (Whom can we thank?_____)

PET INFORMATION

Name:_____ Age/Birthday:_____ ❑ Male ❑ Female

Species (cat, dog, etc.):_____ Breed:_____ Color :_____

Spayed/neutered? ❑ Yes ❑ No

ONLINE PHARMACY

At Farmers Veterinary Hospital, we are committed to creating the best possible experience for our clients and pet patients. Our exclusive on-line pharmacy allows for you to order any flea/tick/ heartworm preventatives, pet food, and medications for your pet; and have them delivered directly to your home. We can provide you with all the information you need to create an account with this service. You can also visit our web site for more information.

❑ **Yes** – I would be interested in this service ❑ **No Thanks**

STATEMENT OF OWNERSHIP

I certify that I am the true owner and/or agent of the above animal(s), and have the authorization to consent to treatment if and when it is needed.

Signature:_____ Date:_____

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED

- In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the veterinarians and support staff of Farmers Veterinary Hospital to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary. Should any additional treatments be needed, we will do our best to reach you for consent prior.
- **If an estimate of the cost of services recommended by the Veterinarian is needed before treatments are performed, please ask for an estimate.**
- I assume full financial responsibility for all charges incurred by my pet. I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible, should complications occur.

For your convenience we accept MasterCard, Visa, Discover Card, AMEX or cash. We also accept Wells Fargo Health Advantage and Care Credit.

Signature of Owner:_____ Date:_____

Submit **Reset**

If you cannot make it to any appointments in the future, please call as soon as possible to reschedule or cancel the appointment. PLEASE NOTE that if you don't call ahead of time to reschedule or cancel, you will incur a $10 charge for a missed appointment , a $15 charge for a missed grooming appointment, and a $25 charge for a missed surgical/dental procedure appointment.