



CHESTER VALLEY VETERINARY HOSPITAL
helping pets enjoy every adventure

Client Information Sheet

Name _____ Home Phone _____ Cell _____
Spouse/Secondary Name _____ Work _____ Cell _____
Mailing Address _____ City _____ State _____ Zip _____
Physical Address _____ City _____ State _____ Zip _____
Email Address _____

(Check all that apply): Military_Y / N Policeman_Y / N Fireman_Y / N Senior Citizen_Y / N

How did you hear about us: Yellow Pages: _____ Internet: _____ Drive by/Sign _____ Friend: (Please specify the referrer's name so we can send a thank you gift): _____

Pet's Name _____ Date of Birth/Age _____ Species _____
Breed _____ Sex M / F _____ Fixed? Y / N Color/Description _____
Microchip# _____ Previous Veterinary Office/Vaccine Clinic _____

Photo/Video Release

I hereby grant permission to the rights of my pet's image, likeness and sound of his/her voice as recorded on audio or video without payment or any other consideration to Chester Valley Veterinary Hospital. I understand that my pet's image may be edited, copied, exhibited, published or distributed and waive any right to royalties or other compensation arising or related to the use of my pet's image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Permission Granted: _____ Permission Denied: _____

Treatment Authorization/Payment Authorization

I hereby authorize Chester Valley Veterinary Hospital's doctor(s) and staff to examine my pet(s) and to discuss findings with me or an authorized representative. I understand that I am entitled to an estimate of charges for the care and treatment of my pet(s). I am also aware that regardless of my decision to proceed with the estimated treatment or not I am responsible for an exam fee.

I hereby consent to the care and treatment of my pet(s) by the staff at Chester Valley Veterinary Hospital. I give my permission to the administration of anesthesia and surgical procedures as seen fit by the physical in the event of an emergency as well as in the treatment of my pet(s).

I understand that an itemized receipt will be presented to me upon the release of my pet(s). I take full financial responsibility of all incurred charges for my pet(s). I also understand that full payment is expected before said pet(s) is released to me.

I fully understand that any pet(s) brought to Chester Valley Veterinary Hospital by the above person/persons or authorized representative will be considered abandoned, if the animal(s) is not collected within 10 days of written notice to the above address. Upon which time Chester Valley Veterinary Hospital has the rights to adopt it out, sell, or euthanize without prejudice to its claims for fees or services rendered.

No Show/Cancellation Policy

I hereby understand that Chester Valley Veterinary Hospital requires a 24 hour notice to reschedule or cancel an appointment. Failure to call and cancel an appointment or arriving 15 minutes late to an appointment will be deemed a "no show". A cancelled or no show appointment will incur a fee at Chester Valley Veterinary Hospital's discretion and can result in the refusal of service at this practice.

I have read and fully understand the above authorizations, policies, payment requirements and risks.

Signature _____ Date _____

Medical History Form



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- | | |
|---|--|
| Y/N Excessive Thirst
How Long? | Y/N Dirty/Smell from Ears
How long? |
| Y/N Poor Balance
How long? | Y/N Scratching Ears/Shaking head
How long? |
| Y/N Excessive Drooling
How long? | Y/N Discharge from eyes
How long? |
| Y/N Lethargic
How long? | Y/N Squinting eyes
How long? |
| Y/N Eating and drinking well
How long? | Y/N Vomiting (Food/Water/Yellow Bile)
How long? |
| Y/N Painful
Where? | How many times per:
Day |
| Y/N Wounds
Where?
When did it happen? | Week
Month |
| Y/N Excessive Panting
How long? | Y/N Lameness or Limping
How Long? |
| Y/N Labored Breathing/Wheezing
How long? | Y/N New or Unusual Lumps
Where?
How Long? |
| Y/N Sneezing/Coughing/Hacking
How long? | Y/N Has Your Pet Been to the Lower 48
When? |
| Y/N Balding/Losing Hair
How long?
Where? | Additional information you think is important
for us to know. |
| Y/N Weight Gain/Loss
How Long? | |
| Y/N Foul Breath
How long? | |
| Y/N Difficulty Urinating
How Long? | |
| Y/N Excessive Urination
How long? | Current Medications: |
| Y/N Change in Urine Color/Odor
How long? | |
| Y/N Urinating outside of litter box
How long? | |
| Y/N Urinating in the house
How long? | |

Has our staff spoken to you about Geriatric blood work? Y/N
If not and you are interested, please ask the front desk or the Doctor.

Geriatric Ages

Cats: Over 10 years old

Dog: Small/Med. mixed breed dogs: Over 10 years old

Large breeds (Over 70lbs) and/or Purebred dogs: Over 8 years old

Owner Signature _____ Date _____