Office Use	
Int. N P	
Dr.	

CEDARCREST

P.O. Box 375, 121 Ladd Road
Fishersville, VA 22939
540-943-7577

Welcome to CEDARCREST! Thank you for trusting us to care for your pet!
Please provide the following information so that we may become better acquainted

Mr./Mrs./Ms./Dr.
____Home Phone: (____) ______________

Address: ____ Driver's License #_______________
(Street address *and* P.O. Box) (City, state and zip code)

Cell Phone: (____) _________________# of Pets in home: Dogs ______Cats _____Other____________________
Employer: ____Work Phone: (____) ______________________
Spouse's Name: ____ Phone: (____) ______________________
Employer: ____Work Phone: (____) ______________________ What email address would be best for us to use to send appt confirmations and medical reminders?
Email: ____

May we use your pet's photo on our website, Facebook, etc..? YES, please do! ______ Thank you, No: _______

**By checking yes you are authorizing CEDARCREST Animal Clinic, its representatives and employees the right to take and/or use photos, videos, etc. of your pet(s) for any lawful purpose, including for example, publicity, illustration, advertising and web content. You are also granting CEDARCREST Animal Clinic permission to use and/or publish the same print/electronically without compensation.

Tell us about your Pets!

Name:		
Type/Breed:		
Color:		
Sex:	Neutered?	Neutered?
Birthdate/Age:		
Diet:		
Microchip #:		
Medical condition or allergies:		
Vaccinations Canine: Feline: Rabies: Other:	(Type; ie; Distemper, Felv, etc.) Yes;______________ Date_______ No Yes;______________ Date_______ No Yes;______________ Date_______ No Yes;______________ Date_______ No	(Type; ie; Distemper, Felv, etc.) Yes;______________ Date_______ No Yes;______________ Date_______ No Yes;______________ Date_______ No Yes;______________ Date_______ No
Where did you acquire this pet?		

Previous Veterinary Hospital____

How did you become aware of CEDARCREST? Yellow Pages _____________ Advertisement________________

Personal Recommendation______________________________ Web Search______________ Other _____________

Payment Policy: Professional fees are due at the time services are rendered. It is our policy to provide a written estimate of fees for any case in which hospital treatment or emergency care is needed. A deposit is required prior to treatment in the amount of 50% of the estimated fees. Please circle your preferred method of payment.

CASH **CHECK** **MC/VISA** **DISCOVER** **CARECREDIT**

Signature of Responsible Agent: ____ **Date:** ____________________