



Client Registration

Client Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone No.: _____ **Work Phone No.:** _____ **Cell phone No.:** _____

E-Mail Address: _____
(If you would like to receive reminders by E-mail)

Employer: _____

Employer's Address: _____
Street City State Zip

Spouse/Partner's Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone No.: _____ **Work Phone No.:** _____ **Cell phone No.:** _____

Spouse's Employer: _____

Employer's Address: _____
Street City State Zip

Spouse's E-Mail Address: _____
(If you would like to receive reminders by E-mail)

Person to contact in case of emergency (third party): _____

Address: _____
Street City State Zip

Home Phone No.: _____ **Work Phone No.:** _____ **Cell phone No.:** _____

How did you hear about us? Referred by friend? Yes _____ No _____

If yes, provide their name so we can say thank you: _____

Yellow Pages: Yes _____ No _____

AAHA: Yes _____ No _____

Cat Adoption: Yes _____ No _____

Healthy Pet: Yes _____ No _____

Sign/Drive by: Yes _____ No _____

Other Vet: Yes _____ No _____

Rescue Group: Yes _____ No _____

School Tour: Yes _____ No _____

Website: Yes _____ No _____

Social Media: Yes _____ No _____



Facebook: Yes _____ No _____

YouTube: Yes _____ No _____

Twitter: Yes _____ No _____

PAYMENT POLICY FOR SERVICES RENDERED

For your convenience, we accept cash, checks, and Visa, Master Card, Discover, American Express, Care Credit, and debit cards. We will be happy to discuss any fees with you before your appointment or give you an estimate at any time for services. It is our policy to charge \$25.00 for any returned checks. There will be a finance charge applied to all accounts unpaid after 30 days. Finance charge is computed by a periodic rate of 1.50% per month, which is the annual percentage rate of 18.00%. There is a minimum finance charge of \$9.00 per month.

FINANCIAL RESPONSIBILITY AGREEMENT

I, the undersigned, understand and acknowledge that if an account balance is not paid in a timely fashion, I will be responsible not only for the balance due but any collection, reasonable attorney fees, and /or court costs that are incurred in the collection process. I understand that Great Falls Veterinary Clinic Inc. reserves the right to add an additional twenty-five to fifty percent fee if my account is sent to outside credit collections and that the Great Falls Veterinary Clinic Inc. will report delinquent accounts to all credit reporting agencies.

I have read the Payment Policy and the Financial Responsibility Agreement and understand its contents.

Date: _____ Client Signature: _____

Patient Registration

Pet's name: _____ Breed: _____ Microchip/Tattoo No.: _____

Date born: _____ Color: _____ Sex: _____ Spay/Neuter: Yes _____ No _____
mm / dd / yy M / F

History of any previous surgery, treatments, or medications: _____

Name of Previous Veterinarian: _____

Address or Phone Number with Area Code, if possible

Dates of Last Vaccinations

Canine

Distemper Vaccine: _____
mm / dd / yyyy

1 year: _____
mm / dd / yyyy

3 year: _____
mm / dd / yyyy

Hepatitis Vaccine: _____
mm / dd / yyyy

1 year: _____
mm / dd / yyyy

Feline

Distemper/Upper Respiratory: _____
mm / dd / yyyy

1 year: _____
mm / dd / yyyy

3 year: _____
mm / dd / yyyy

Parainfluenza Vaccine: _____
mm / dd / yyyy

1 year: _____
mm / dd / yyyy



3 year: _____
mm / dd / yyyy

3 year: _____
mm / dd / yyyy

Parvo. Vaccine: _____
mm / dd / yyyy

Leptospirosis Vaccine: _____
mm / dd / yyyy

1 year: _____
mm / dd / yyyy

Feline Leukemia Test: _____
mm / dd / yyyy

3 year: _____
mm / dd / yyyy

Rabies Vaccine: _____
mm / dd / yyyy

Bordetella Vaccine: _____
mm / dd / yyyy

1 year: _____
mm / dd / yyyy

Rabies Vaccine: _____
mm / dd / yyyy

Fecal Exam: _____
mm / dd / yyyy

1 year: _____
mm / dd / yyyy

FIV Test: _____
mm / dd / yyyy

3 year: _____
mm / dd / yyyy

Fecal Exam: _____
mm / dd / yyyy

Last Heartworm Check: _____
mm / dd / yyyy

AVIAN

Name: _____ Species: _____ Age: _____ Sex, if known _____ Color: _____

Wild caught / captive bred? Yes _____ No _____ Hand-raised? Yes _____ No _____

Only bird / housed with others? Yes _____ No _____ Any quarantine period? Yes _____ No _____

If so, how long? _____ Bought from: _____ Owned how long? _____

Kept indoors / outdoors? Yes _____ No _____ If indoor, which room of house? _____

Approx. cage size? _____ Type of bedding used? _____ Cleaning agents used? _____

Diet: _____ Treats? _____ Any vitamins/minerals added to food/water? Yes _____ No _____

If so, what? _____ Does the bird get a "bath"? Yes _____ No _____

If so, _____ times / week Any playtime outside of cage: Yes _____ No _____

If so, how often? _____ Is playtime supervised? Yes _____ No _____ Seen by a vet? Yes _____ No _____

If so, where: _____ Ever been ill before? Yes _____ No _____



If so, for what? _____

Ever been vaccinated? Yes _____ No _____ If so, with what? _____

Last vaccine date: _____ Any history of feather picking? Yes _____ No _____
mm / dd / yyyy

Any abnormal feather growth? Yes _____ No _____ Last general molt: _____

Other: _____

If your pet is hospitalized, we will make attempts to reach you at the phone numbers you provide on treatment day. If we are unable to make contact with you, do you authorize any necessary treatments?

Yes _____ No _____

SMALL MAMMALS

Name: _____ Species: _____ Age: _____ Sex, if known: _____ Color: _____
M / F

Housed alone or with others? Yes _____ No _____ Any exposure to other animals? Yes _____ No _____

If so, what: _____ Any quarantine period? Yes _____ No _____

If so, how long? _____ Bought from? _____ Owned how long? _____

Kept indoors/outdoors? Yes _____ No _____ Type of cage: _____ Approx. cage size: _____

Type of bedding used: _____ Cleaning agents used? _____ Diet: _____

Any vitamins/minerals added to food/water? Yes _____ No _____ Treats? Yes _____ No _____

If so, what: _____ Any playtime outside of cage? Yes _____ No _____

If so, how long per day? _____ Is playtime supervised? Yes _____ No _____

Ever seen by vet before? Yes _____ No _____ If so, where: _____

Ever been ill before? Yes _____ No _____ If so, for what? _____

Ever been vaccinated? Yes _____ No _____ If so, with what? _____

Last vaccine date: _____ Other: _____
mm / dd / yyyy

REPTILES

Name: _____ Species: _____ Age: _____ Sex, if known: _____ Color: _____
M / F

Wild caught / captive bred? Yes _____ No _____ Housed with others? Yes _____ No _____



If so, what: _____ Any quarantine period: Yes _____ No _____ If so, how long: _____

Bought from: _____ Owned how long: _____ Kept indoors/outdoors: Yes _____ No _____

Type of cage: _____ Approx. cage size: _____ Type of bedding used: _____

Cleaning agents used: _____ Diet: _____ How many hrs. of light daily? _____

Do you use a full spectrum (UVB) light? Yes _____ No _____ Last time light was changed? _____

Type of heat source used? _____ Warm Temp.: _____ Cool Temp.: _____

Diet: _____ If fed rodents, are they live/dead/stunned? _____ Fed how often? _____

Any vitamins/minerals added to food? Yes _____ No _____ If so, what? _____

How often added to food? _____ Water bowl kept in cage? Yes _____ No _____ If so, how big? _____

Is cage misted? Yes _____ No _____ If so, how many times per day/week? _____

Ever been seen by vet before? Yes _____ No _____ If so, for what? _____

Ever been ill before? Yes _____ No _____ If so, for what? _____

Last shed? _____ Was it a complete shed? Yes _____ No _____ Other? _____

If your pet is hospitalized, we will make attempts to reach you at the phone numbers you provide on treatment day. If we are unable to make contact with you, do you authorize any necessary treatments?

Yes _____ No _____



Virginia Veterinary Disclosure

(Please read carefully before signing)

Great Falls Animal Hospital (GFAH) has business and medical staffing hours as follows:

Monday through Friday: 7:00 am to 8:00 pm

Saturday: 8:00 am to 3:00 pm

Sunday: Closed

Holidays: Closed

Therefore, this is to inform you, that we have no in-house, on-duty continuous medical staff care (although staff does come in between 10:00 pm -11:00 pm to check patients):

(1) **Overnight**, from closing time at 8:00 pm to opening time at 7:00 am;

(2) **Weekends**, from closing time Saturday at 3:00 pm to opening time Monday morning at 7:00 am;

(3) **Holidays**, from closing time before the holiday at 8:00 pm to opening time the day after the holiday at 7:00 am;

(4) **Holidays** falling on Monday, from closing time Saturday at 3:00 pm to opening time on Tuesday at 7:00 am;

Please note: The Doctors and GFAH Staff Members do come in to medicate, feed, and care for your pets during weekends and holidays.

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

Date: _____ **Client Signature:** _____

Client ID #: _____ **Witness:** _____