



## Jacksonville Veterinary Hospital

14240 Jarrettsville Pike  
Phoenix, Maryland 21131  
410-666-1390  
[www.jvh.info](http://www.jvh.info)

### New Client / New Patient Registration

CLIENT INFORMATION: Have you ever been to this hospital before?  Yes  No

Primary Owner Name \_\_\_\_\_

Spouse/Emergency Contact \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell ( ) \_\_\_\_\_ - \_\_\_\_\_

Best number to reach you ( ) \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_

### REQUEST FOR PREVIOUS MEDICAL INFORMATION

PRIOR TO YOUR FIRST APPOINTMENT, IT IS IMPERATIVE FOR OUR OFFICE TO HAVE ANY PREVIOUS RECORDS/ HISTORY. \*\*\*Please request all previous records, lab results and radiographs from your previous veterinary clinic. Your previous vet may submit them to: [JacksonvilleVet@jvh.info](mailto:JacksonvilleVet@jvh.info) .

This must be completed PRIOR to your pet's initial appointment.

### BASIC PATIENT INFORMATION

#### Pet 1

Name \_\_\_\_\_ species \_\_\_\_\_ sex \_\_\_\_\_ Spayed or Neutered?

\_\_\_\_\_ Breed \_\_\_\_\_ Color \_\_\_\_\_ Age \_\_\_\_\_

Current medications \_\_\_\_\_

Any medical problems \_\_\_\_\_

**Pet 2**

Name \_\_\_\_\_ species \_\_\_\_\_ sex \_\_\_\_\_ Spayed or Neutered?  
\_\_\_\_\_ Breed \_\_\_\_\_ Color \_\_\_\_\_ Age \_\_\_\_\_

Current medications \_\_\_\_\_

Any medical problems \_\_\_\_\_

**Pet 3**

Name \_\_\_\_\_ species \_\_\_\_\_ sex \_\_\_\_\_ Spayed or Neutered?  
\_\_\_\_\_ Breed \_\_\_\_\_ Color \_\_\_\_\_ Age \_\_\_\_\_

Current medications \_\_\_\_\_

Any medical problems \_\_\_\_\_

Do you board your pet when you are away? \_\_\_\_\_

Would you like a tour of the hospital or boarding facility? \_\_\_\_\_

How did you hear about Jacksonville Veterinary Hospital? \_\_\_\_\_

Previous Veterinary Hospital \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax \_\_\_\_\_

Previous Veterinarian \_\_\_\_\_

**IMPORTANT FINANCIAL INFORMATION**

Do you currently have pet insurance? \_\_\_\_\_ If so, what is the name of your insurance company? \_\_\_\_\_

Payment is expected when services are rendered. We accept cash, checks (with proper ID) and Visa/MasterCard and Discover. We also offer Care Credit with 6 months interest free financing.

I hereby authorize the doctor and technicians to administer services/treatment as explained to me by the doctor. I assume all financial responsibility for all charges incurred for the care and treatment of my pet(s). I understand that services are to be paid for when rendered.

At my request, I will receive a written estimate for services for anything other than routine care which I may decline for any reason.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Owner/agent

Date