6719 Lowell Avenue, McLean, VA 22101
Phone: 703-356-5582 Fax: 703-893-2441
E-mail: info@odahcenter.com
Website: www.odahcenter.com

NEW CLIENT FORM

Owner's Name: Ms/Mrs/Mr/Dr: ______________________________ Spouse/Other: ____________________________________

Owner's Date of Birth: ____________________
For controlled drug prescription reporting purposes

Spouse/Other's Date of Birth: __________________
For controlled drug prescription reporting purposes

Address: ____

City: ____ State: ___________________ Zip: ____________________

Cell phone: Ms/Mrs/Mr/Dr (_____) _______________________ Cell phone: Ms/Mrs/Mr/Dr (_____) ______________________

Work Phone: Ms/Mrs/Mr/Dr (_____) ______________________ Work Phone: Ms/Mrs/Mr/Dr (_____) _____________________

Home Phone: (_____) ________________________________ Home Phone: (_____) _______________________________

Email Address: ____________________________________ Alternate Email:____

May we use your pet's photo(s) on our website and/or in other publications? YES / NO

How did you first hear of our hospital?
☐ Someone we may thank?
First Name: ________________________ Last Name: ____________________________________

Pet's Name, if known: ______________________________________

☐ AAHA Referral ☐ Hospital Sign ☐ Yellow Pages ☐ Web Site / Internet ☐ Local Newspaper
☐ Social Media: ________________________ ☐ Other: ___________________________

Payment for all services is due in full at the time of service. An estimate can be provided upon request; however, please note that it is an **estimate**, not a binding quote. The final cost may vary based on actual time, materials, or other factors that arise during the course of service.

We accept credit cards, debit cards, cash and checks. A **3%** fee will be added to all credit card payments. This fee is not applied to cash, check and debit cards. Any returned checks will be subject to a **returned check fee of $35** and forfeit the promisors' options for check payments in the future. If payment is not received at the time of service, a **$15 monthly billing fee** will be applied to your account. This fee will be assessed each month until the outstanding balance is paid in full. If your balance remains unpaid for more than 90 days, we reserve the right to initiate collection efforts. You agree to be responsible for any collection costs, including but not limited to: **Collection Agency Fees**: You will be responsible for any fees incurred from third-party collection agencies hired to recover the outstanding balance. **Attorney Fees**: If the account is referred to an attorney for legal action, you will be responsible for any legal fees, court costs, and attorney fees incurred in the process of collecting the debt.

By scheduling services with us, you agree to abide by the terms of this payment policy. If you have any questions or concerns regarding our payment policy, please contact us. I also agree to exclusive venue and jurisdiction of Fairfax County, Virginia for all matters of litigation regardless of the location of the promisor.

Name of veterinarian and clinic that has most recent medical history: ___________________________________

Signature: ____ **Date**: ________________________

PET MEDICAL HISTORY

	PET #1	PET #2	PET #3
PET'S NAME:			
SPECIES (Dog/Cat/Other)			
BREED			
DESCRIPTION (Color)			
DATE OF BIRTH			
SEX	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
LENGTH OF TIME OWNED			
NEUTERED OR SPAYED?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
MICROCHIP NUMBER (If applicable)			
DIET (kind of pet food)			
HOW OFTEN FED			
TYPE OF GROOMING PRODUCTS			
HOURS SPENT OUTSIDE EACH DAY			
ALLERGIES			
HEARTWORM PREVENTION			
DENTISTRY			
PRIOR ILLNESS			
PRIOR SURGERY			

PET NOTES

PET ORIGIN: ☐ Humane Society/Shelter ☐ Pet Shop ☐ Kennel ☐ Stray
☐ Advertisement ☐ Breeder ☐ Individual (Nonbreeder)