



Loving Touch Animal Hospital  
 628 Cambridge Street, Ste. 111  
 Fredericksburg, VA 22405  
 540-371-7729  
 Fax 540-371-1589

### New Client Registration Form

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Co-Parent: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Co-Parent Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

May we email you information about our payment plan, wellness plans, and other ways to save? Yes / No

Are you or your spouse Active Military? Yes / No \*Active Duty, Retirees, & Dependents receive a 5% discount if ID is provided

How did you hear about our practice? Friend/Family/Co-worker (Name) \_\_\_\_\_

Google \_\_\_\_\_ Facebook \_\_\_\_\_ Yelp \_\_\_\_\_ Other: \_\_\_\_\_

	Pet #1	Pet #2	Pet #3
Pet's Name			
Species (dog/cat)			
Breed			
Date of Birth			
Color			
Sex			
Spayed/Neutered?			
Microchip?			

	Pet #4	Pet #5	Pet #6
Pet's Name			
Species (dog/cat)			
Breed			
Date of Birth			

<b>Color</b>			
<b>Sex</b>			
<b>Spayed/Neutered?</b>			
<b>Microchip?</b>			

Do you have current Pet Insurance? Yes/ No Insurance Company

Name: \_\_\_\_\_

Name and Phone number of Previous Veterinary Practice:

\_\_\_\_\_

Do any pets have previous chronic conditions or surgeries?

\_\_\_\_\_

\_\_\_\_\_

Do any pets have allergies to vaccinations or medications?

\_\_\_\_\_

\_\_\_\_\_

Are any pets on a special diet or medications?

\_\_\_\_\_

\_\_\_\_\_

## **Authorization**

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described patient. I assume full responsibility for all changes incurred for the care of this animal. I also understand that payment is due at the time services are rendered and that a deposit may be required for surgical treatment. I may opt to apply for a payment plan through VetBilling for certain Wellness Plans, treatments and procedures. If approved by VetBilling, I will be responsible for a deposit and monthly payments disclosed to you in writing.

Initial: \_\_\_\_\_

Our practice files insurance claims for Trupanion pet insurance clients. If the claim is approved, clients are responsible for their co-pay. The balance is paid directly to the hospital. Please note this insurance is not recommended for any patient with a pre-existing condition. The insurance will not cover wellness care or dentistry. If you have a young pet or a pet with no pre-existing conditions and would like a certificate for one month of free Trupanion pet insurance, please ask the Receptionist at check in.

Initial: \_\_\_\_\_

In order to balance our schedule, we need you to keep your appointment or cancel/re-schedule with 48 hours advanced notice. If an appointment is missed without at least 48-hours prior notice, there will be a \$25 missed appointment fee. The missed appointment fee is for all appointments including routine, drop off, and technician appointments. Surgery patients who are a no-show for their surgery appointment will forfeit their deposit.

Initial: \_\_\_\_\_

If your pet is not picked up by our closing time there will be a \$25 late pickup fee assessed and your pet will be considered a boarder and boarding fees will be applied.

Initial: \_\_\_\_\_

We love our clients and patients. We want to share your adorable pets with our social media fans. Please give us authorization to post photos of your fur kids on our Facebook, Twitter and Website. You can also go to our website and post a photo and description of your furry family members at <http://www.LovingTouchVets.com>. I authorize my patient's pictures

to be utilized in materials to represent Loving Touch Animal Hospital including, but not limited to our Facebook Page, Twitter, and Website.

Initial: \_\_\_\_\_

Our hours of operation are Monday, Tuesday, Thursday and Friday 9:00am-5:00pm, Wednesday 11:00am-6:00pm. If you have an emergency, we will stay after hours to take care of your pet. We care about our patients and we do not want to send you to the emergency animal hospital during our normal business hours. In order to help us help you, we urge you to contact us first thing in the morning in the event of an emergency to ensure we have adequate staffing to take care of your patient.

Initial: \_\_\_\_\_

Patient records may be requested by the patient portal or email to: [info@lovingtouchvets.com](mailto:info@lovingtouchvets.com). Please ensure that you provide a complete mailing address, email, and call back number to expedite your request. Please allow up to seven business days to process your request.

Initial: \_\_\_\_\_

For refill(s) of prescriptions, please allow two business days for processing. We accept requests in person, via phone, and email. Please ensure to include the patients name, medication to refill, your name, and contact phone number.

Initial: \_\_\_\_\_

Patient Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_