Office Use

Int.	N	P
Dr.		

CEDARCREST

P.O Box 375, 121 Ladd Rd
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

Ms., Mrs., Mr.,
or Dr._____SSN:_____Home:Phone:(____)_____
Address:_____Drivers 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:_____ SSN:_____
Employer:_____ Work Phone:(____)_____
Would you like your pet's reminders sent by e-mail? E-mail: _____

Tell us about your Pets!

Name:		
Type / Breed:		
Color:		
Sex:	Neutered?	Neutered?
Birthdate/Age:		
Diet:		
Microchip Number:		
Medical condition or allergies:		
Vaccinations	*(Type; ie; Distemper, Felv, etc.)*	*(Type; ie; Distemper, Felv, etc.)*
Canine:	Yes;_____ Date_____ No	Yes;_____ Date_____ No
Feline:	Yes;_____ Date_____ No	Yes;_____ Date_____ No
Rabies:	Yes;_____ Date_____ No	Yes;_____ Date_____ No
Other:	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_____

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** **American Express** **CareCredit**

Signature of Responsible Agent:_____ **Date:**_____