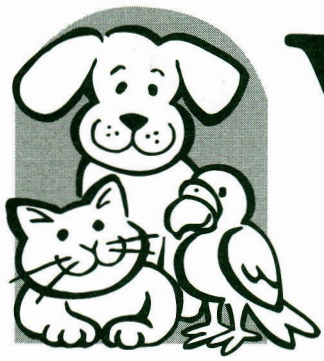

Welcome

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank you!

REGISTRATION

Date_____

Owner _____

Address _____

_____

Spouse _____

Home Phone_____ Work Phone_____ Spouse Work Phone _____

Cell _____

How did you learn of our clinic? ☐ Yellow Pages ☐ Client/Friend ☐ Drive by/Neighborhood ☐ School/Troop Tour ☐ Stream Valley Mailer ☐ Red Community Book ☐ Online

Number of pets: Dogs_____ Cats_____ Other (specify) _____

Reason for visit _____

PET HEALTH HISTORY

Name of pet_____ ☐ Dog ☐ Cat ☐ Other_____

Breed_____ Color_____ Birthdate_____

☐ Male ☐ Neutered ☐ Female ☐ Spayed

Vaccination History (Date and type of last vaccinations)_____

☐ Provided _____

_____

Please check (✓) any symptoms or problems that you have noticed about your pet.

- ☐ Behavior Problems
- ☐ Bleeding Gums
- ☐ Breathing Problems
- ☐ Coughing
- ☐ Diarrhea
- ☐ Eye Bulging or Bloodshot
- ☐ Gagging
- ☐ Lack of Appetite
- ☐ Limping
- ☐ Loss of Balance
- ☐ Scooting
- ☐ Scratching
- ☐ Seems Depressed
- ☐ Shaking Head
- ☐ Sneezing
- ☐ Thirst and/or Urination Increased
- ☐ Vomiting
- ☐ Weakness
- ☐ Other_____

_____

Pet's current medications_____

_____

Describe your pet's diet_____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner_____ Date_____

Modern Medicine • Hometown Hospitality

Stream Valley Veterinary Hospital

Stream Valley Veterinary Hospital
42902 Waxpool Road
Ashburn, VA 20149
Phone: (703) 723-1017

In accordance with Virginia Law, we are required to inform you that Stream Valley Veterinary Hospital (SVVH) does not provide 24-hour medical care. Our office hours are as follows: Monday – Friday 7am – 7pm, Saturday 8am – 3pm and Sunday 5pm – 7pm (for boarder pick up only). Our doctors are available to provide medical care generally Monday – Friday 8:30am – 6pm (with a 12pm – 2pm lunch break) and Saturday 8:30am – 2pm (with a 12pm – 1pm lunch break). Should your pet have an emergency outside of these hours, you may need to call or be referred to the Animal Emergency Hospital at The Life Centre in Leesburg at (703) 777-5755.

_____
Print Name

_____
Signature

_____ _____
Home Phone Cell Phone

_____
Email address

_____
Date

In providing the above email address and/or cell phone number, I give Stream Valley Veterinary Hospital permission to contact me via email and/or text to remind me of my pet's appointments and vaccine/medical procedures, to share educational materials, and to alert me to certain events or issues within the practice.
Note: many email and text programs are "opt out" should you wish not to participate, and you may contact us with any specific concerns.

☐ ☐ ☐
I agree (email) I agree (text) I do NOT agree

The following person(s) is/are authorized to make medical and/or financial decisions in my absence. It is my responsibility to modify this document in the event of any changes.

_____ _____
authorized to make decisions authorized to make decisions

Modern Medicine • Hometown Hospitality

Stream Valley Veterinary Hospital

Photograph / Video Release Form

Stream Valley Veterinary Hospital (SVVH) maintains an online (website and various social media accounts) and a public relations (flyers, mailings, etc.) presence for purposes including marketing and client education. Part of this presence includes posting and disseminating photographs and digital videos of our practice and its daily workings. Therefore, we may be interested in using images of your pet(s) and/or family as a part of the effort to maintain, expand, and educate the public about our business and services. We would refer to pets and people by *first name only*, if at all.

Please let us know how we may use/post photographs and/or digital video of your pet(s) and/or family:

☐ SVVH has my permission to use or post **BOTH** photographs and digital videos of my pet(s) and/or family.

☐ SVVH has my permission to use or post **ONLY** photographs of my pet(s) and/or family.

☐ SVVH has my permission to use or post photographs and digital videos of my pet(s) and/or **adult (18+ years old) family members ONLY.**

☐ SVVH has my permission to use or post photographs and digital videos of my pet(s) **ONLY.**

☐ SVVH may **NOT** use or post photographs or digital videos of my pet(s) and/or family.

_____
Name (print)

_____ _____
Signature Date

Modern Medicine • Hometown Hospitality

Stream Valley Veterinary Hospital

Client Record Release Form

I, _____, give permission to Stream Valley Veterinary Hospital to receive and review all medical and vaccination records that are on file at _____. I fully understand that by signing this document the records will be released for the animal(s) that I have listed below. I give permission to have the records faxed to (703)723-8509 or mailed to Stream Valley Veterinary Hospital as soon as possible.

Pet (s):

_____
_____
_____
_____

The above records transfer is for the purpose of:

☐ I intend to pursue my veterinary services at Stream Valley Veterinary Hospital

☐ I intend **ONLY** to Board, participate in daycare or have my pet groomed at Stream Valley Veterinary Hospital.

_____ _____

Client's Signature Date