Animal Rehab & Pain Center

Virginia Scrivener DVM
Certified Canine Rehabilitation Practitioner
Certified Veterinary Pain Practitioner
Certified Veterinary Medical Acupuncturist

www.AnimalRehabVet.com

27 East Baltimore Street ◆ PO Box 841
Funkstown, MD 21734
301-745-8975

Throughout the patient's treatment, we maintain open communication with your primary care vet, and upon completion of the treatment your pet will return to their veterinarian for routine care. Please feel free to discuss any part of the MEDICAL PLAN with the staff. PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. Your pet must be parasite free and up to date on their rabies vaccine upon admission to the hospital. This policy is to prevent unnecessary transmission of parasites to other patients as well as the protection of your pet. If your pet has parasites or needs their rabies vaccine, they will be treated at your expense.

To insure the best care possible, please take the time to fill in this form completely.
Thank you for trusting your best friend(s) to us.

In order to open an account with us you must be 18 years of age and provide us with at least one form of identification. Your information will be kept confidential. The social security number **MUST** be that of the primary owner.

For office use only- Today's date: _____ *AHC Representative:* _____ *Client ID:* _____

OWNER INFORMATION

Owner: _____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. SS# _____

Street address: _____ P.O. Box: _____ City, State, Zip: _____

Preferred Phone: _____ ☐ home ☐ cell

Employer's Name _____ Work Phone _____

Employer's address
(incl. City, State & Zip) _____

Co-Owner/Spouse Name: _____ Social Security Number _____

Co-Owner/Spouse Phone: _____ Co-Owner/Spouse Cell Phone: _____

Spouse's Employer's Name _____ Work Phone _____

Employer's address
(incl. City, State & Zip) _____

Emergency contact name: _____ Phone number: _____

Are you eligible for a senior citizen discount? (65 years or older) ☐ Yes ☐ No

Are you eligible for a military discount? (active or retired military with ID) ☐ Yes ☐ No

E-mail address _____

We will not sell your e-mail address to anyone and will only be used by our office.

PET'S INFORMATION

Please give any previous records to the receptionist so we may copy them for our records.

Pet's Name: _____ Age/Birthdate:_____

☐ Dog ☐ Cat ☐ Other _____ Breed: _____

☐ Male ☐ Neutered ☐ Female ☐ Spayed

Color(s):_____ Distinguishing Markings: _____

Relevant History

_____

_____

_____

_____

Please list any relevant surgeries, and how they were preformed

_____

_____

_____

_____

_____

Is your pet current on their rabies? ☐ YES ☐ NO Expiration Date: _____

Pet Insurance Company _____ Policy Number _____

AUTHORIZATION

I hereby authorize Animal Pain and Rehab Center to examine and treat my pets. I assume responsibility for all charges incurred in the care of my animals. I also understand that these charges will be due at the time of release and that a deposit may be required for surgical treatment or hospitalization. *We will gladly prepare a written estimate for your pet's care at any time. Just ask one of our staff members.*

Method of payment: ☐ cash ☐ VISA MasterCard DISCOVER NOVUS ☐ check ☐ CareCredit Patient Payment Plans

Signature of responsible party _____