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

Thank you for giving us the opportunity to care for your pet. Please help us meet your needs by taking a moment to complete both sides of this information sheet.

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

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Home Phone: (____) _____

Work Phone: Ms/Mrs/Mr/Dr (____) _____ Work Phone: Ms/Mrs/Mr/Dr (____) _____

Cell phone: Ms/Mrs/Mr/Dr (____) _____ Cell phone: Ms/Mrs/Mr/Dr (____) _____

Email Address: _____ Alternate Email: _____

May we send text messages? YES / NO Preferred cell phone number for texts: (____)_____
Would you like to receive medical reminders via email? YES / NO
May we use your pet's photo(s) on our website and/or in other publications? YES / NO

We will gladly prepare an estimate if you desire. Please ask the receptionist or doctor.
PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

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
☐ Other: _____

Comments: _____

TO PREVENT THE SPREAD OF INFECTIOUS DISEASES AND PARASITES, I UNDERSTAND THAT HOSPITALIZED AND BOARDED PETS MUST BE CURRENT ON ALL VACCINES AND FREE OF INTERNAL AND EXTERNAL PARASITES. IF NOT, THE HOSPITAL WILL TREAT AND VACCINATE AT REGULAR HOSPITAL FEES. I ALSO UNDERSTAND THAT IF ANY BALANCE IS NOT PAID IN A TIMELY FASHION, THAT NOT ONLY WILL I BE RESPONSIBLE FOR THE BALANCE DUE, BUT ANY COLLECTION AND/OR REASONABLE ATTORNEYS' FEES THAT ARE INCURRED IN THE ATTEMPT TO COLLECT THIS DEBT AND I AGREE TO EXCLUSIVE VENUE AND JURISDICTION OF FAIRFAX COUNTY, VIRGINIA FOR ALL MATTERS OF LITIGATION REGARDLESS OF THE LOCATION OF THE PROMISOR.

☐ I will be using ODAHCenter strictly for Boarding/Grooming
☐ I will be using ODAHCenter for Veterinary care and possibly Boarding/Grooming

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

Signature: _____ Date: _____

PLEASE COMPLETE REVERSE SIDE

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
DIET (kind of pet food)			
HOW OFTEN FEED			
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)