BEECHWOLD
VETERINARY HOSPITAL

4590 Indianola Avenue Columbus, Ohio 43214
614.268.8666 bvh@beechwoldvet.com

beechwoldvet.com

AAHA ACCREDITED
The Standard of Veterinary Excellence

Thank you for choosing Beechwold Veterinary Hospital and giving us the opportunity to serve you and your pet. To assist in the best care possible, please take a few minutes and complete this form in its entirety. Please print clearly.

Owner Name: _____ Please circle one: Mr. Mrs. Ms. Dr.

Mailing Address: _____
Street City State ZIP

Home Phone#: _____ Cell Phone#: _____ Work #: _____

Employer: _____

Co-Owner Name: _____ Co-Owner Phone #: _____

Co-Owner Relationship to Owner: _____

BVH utilizes the client email address for communication on updates, vaccine reminders, newsletter and Petly. Please *print clearly* your email address:_____

How did you hear about us:

☐ Neighborhood ☐ Yellow Pages ☐ Mailing ☐ BVH Website ☐ Google

☐ BVH Online Store ☐ Returning Client ☐ Facebook

☐ Referral from another veterinarian (please provide name): _____

☐ Friend/Existing Client (please provide name): _____

☐ Other: _____

I assume responsibility for all charges incurred for the care of this patient(s). I understand that all charges will be paid at the time of service. I understand Beechwold Veterinary Hospital, Inc. does not authorize any billing. I understand a deposit may be required for any surgical, emergency or hospitalization service. Payments can be made with cash, check, Visa, Mastercard, Discover, or American Express. Beechwold Veterinary Hospital, Inc. offers CareCredit as a third party billing option. There will be a $35.00 fee for any returned payment.

PLEASE SEE RECEPTIONIST FOR ELECTRONIC SIGNATURE.

Pet health information is located on the reverse side of this form – please complete in its entirety.

In accordance with county ordinance and for the protection of our doctors and staff, Beechwold Veterinary Hospital, Inc. requires all patients to have a current rabies vaccine. If the patient received a rabies vaccine at another location, proof of vaccine will be required. A waiver can be authorized by your veterinarian for certain medical conditions.

Pet Name: ___________________________________ **Breed:** _____________________________________

Species: Cat Dog Other___________________ **Color:** ______________________________________

Select One: Male Neutered Female Spayed **Date of birth or age:** ___________________________

Microchip ID # _______________________________

Does this pet have a Pet Insurance Policy: Yes No **If Yes, what company:** ______________________________

Name/Phone # of previous veterinary services: ____

Pet Name: ___________________________________ **Breed:** _____________________________________

Species: Cat Dog Other___________________ **Color:** ______________________________________

Select One: Male Neutered Female Spayed **Date of birth or age:** ___________________________

Microchip ID # _______________________________

Does this pet have a Pet Insurance Policy: Yes No **If Yes, what company:** ______________________________

Name/Phone # of previous veterinary services: ____

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