

# VALLEY CENTRAL VETERINARY REFERRAL AND EMERGENCY CENTER

210 Fullerton Avenue, Whitehall, PA 18052  
Phone (610) 435-1553 Fax (610) 435-6378  
www.vcvrec.com



## **SURGERY**

Carlos Hodges, DVM, MS, PC  
*Practice Limited to Surgery*  
Guy DeNardo, DVM  
*Practice Limited to Surgery*  
Angela Gifford, DVM, DACVS  
Daphne Clendaniel, VMD, MS  
*Practice Limited to Surgery*

## **INTERNAL/NUCLEAR MEDICINE**

Ronald Hodges, DVM, PC, DACVIM  
Candace Carter, DVM, PhD, DACVIM

## **OPHTHALMOLOGY**

Mary Landis, VMD, MA  
*Practice Limited to Ophthalmology*

## **ONCOLOGY**

Kate Vickery, VMD, MS, DACVIM  
Christine Mullin, VMD, DACVIM

## **BEHAVIOR**

Robin Stephan

## **CARDIOLOGY**

Dennis Burkett, VMD, PhD, DACVECC, DACVIM  
Meg Sleeper, VMD, DACVIM

## **ACUPUNCTURE**

Lee Simpson, DVM, CVA, CVC  
Diane Gabriel, VMD, CVA

## **EMERGENCY**

Karen Patton, DVM  
Heather Regan, VMD  
Joshua Sprague, DVM  
Matthew Mink, DVM

## **CLINICAL PATHOLOGY**

Kristin Fisher, DVM, MS, DACVP

## **CLIENT INFORMATION**

Date: \_\_\_\_\_ Patient I.D. #: \_\_\_\_\_ Office Use Only  
Owner Name: \_\_\_\_\_ Spouse/Other: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

## **OWNER INFORMATION**

Email: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_  
Secondary Phone: \_\_\_\_\_

## **SPOUSE/OTHER INFORMATION**

Email: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_  
Secondary Phone: \_\_\_\_\_

## **PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Dog \_\_\_ Cat \_\_\_ Breed \_\_\_\_\_  
Circle One: Male/Intact Male/Neutered Female/Spayed Female/intact  
Birth Date: \_\_\_\_\_ How long have you owned this pet? \_\_\_\_\_ Color: \_\_\_\_\_  
Referring Veterinarian Name: \_\_\_\_\_ Referring Hospital Name: \_\_\_\_\_  
Did you bring X-rays and/or medical records from your veterinarian? Yes/No  
Date of Last Rabies Vaccine: \_\_\_\_\_ Reason for Visit (primary complaint): \_\_\_\_\_  
Please list any of your pet's drug allergies or special problems that we should be aware of: \_\_\_\_\_  
Have any doctors at VCVREC seen your pet in the past? Yes/No  
If yes, which doctor(s), which pet(s), and date(s): \_\_\_\_\_  
Have you heard about our Center prior to this visit? Yes/No If yes, explain: \_\_\_\_\_  
May we use images of your pet in advertising and/or social media such as Face Book or Twitter? Yes/No

## **Payment Information**

Following the doctor's examination, we will provide you with an estimate of fees. **All professional fees are due at the time services are rendered, with a 100% deposit required to begin diagnostics, surgery, and/or emergency treatment.** We accept cash, check (with appropriate identification and check approval), & all major credit cards. We can help you establish a payment arrangement if you are approved by GE Capital - Care Credit® prior to treatment. We encourage you to discuss all fees with the doctor before services are performed.

**VCVREC is comprised of multiple departments within the same center. Charges that are assessed for your pet will be billed separately through each appropriate department. If you have any questions, please be sure to ask any of our office staff.**

SIGNATURE OF RESPONSIBLE PARTY: \_\_\_\_\_ DATE: \_\_\_\_\_