VDx®
Veterinary Diagnostics

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NEW VDx CLIENT INFORMATION

Clinic name: ____

Account #: _____________________________
(VDx to assign)

Mailing address:

____
____
____
(Statements will be mailed to this address the first of each month for the previous month's services.)

Address for sample pickup (if different):

____
____
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Phone #:_________________

After hours phone #:______________
(So we can return calls at lunch, after closing, etc…)

Fax #:___________________
(Reports will be sent by fax to this number)

E-mail address:___________________

Preference for results: [ ] **Fax**, [ ] **E-mail** or [ ] **Both**

Doctors' names (Please also enter doctor e-mails if would like to get copies of submission results also sent directly.)

__________________________ E-mail:__________________________
__________________________ E-mail:__________________________
__________________________ E-mail:__________________________
__________________________ E-mail:__________________________

Head Tech's name:____
(or other contact person)

Clinic Hours: ____

What motivates you to open an account with VDx? Please check all which apply

[ ] Quality.
[ ] Service.
[ ] Price.
[ ] Recommendation by general practice colleague.
[ ] Recommendation by specialists colleague.
[ ] Personal experience with VDx at another practice.
[ ] Molecular diagnostics (PARR testing, Flow Cytometry)
[ ] Dissatisfaction with another lab.
[ ] Other: _____________________________________

When complete, please return to VDx via fax (1-530-753-4055)