Please complete the form, print and bring it to your first appointment.

Eye Care® FOR ANIMALS
Seeing life through your pet's eyes

NEW CLIENT FORM

Thank you for giving Eye Care for Animals the opportunity to care for your pet.
So that we may become better acquainted, please complete the following:

Mr. Mrs.
Ms. Dr. Responsible Party #1 _____ Responsible Party #2 _____

Address _____ City _____ St _____ Zip _____

Primary Contact #_____ Secondary Contact #_____

Email Address _____

Employer #1 _____ Address _____ Phone _____

Employer #2 _____ Address _____ Phone _____

Referring Doctor _____ Hospital _____

Regular Doctor (if different than above) _____ Hospital _____

PET INFORMATION
Please complete the following for the pet we are seeing today:

Name of Pet _____ Dog/Cat/other _____ Breed _____

Approximate Date of Birth or Age _____ Sex _____ Spayed/Neutered _____ Color _____

Known Drug Allergies:_____

_____

Other Medications Your Pet Is Taking: _____

_____

_____

I authorize and direct the veterinarians at the *Eye Care* FOR ANIMALS to diagnose, prescribe, perform minor therapeutic procedures, that their judgement may dictate to be advisable for the patient's well being. No warranty or guarantee has been made as to the result or cure.

ALL FEES ARE REQUIRED TO BE PAID IN FULL UPON COMPLETION OF EACH VISIT.

In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all cost included in said unpaid balance, including a reasonable collection and/or attorney's fees.

Signature of Responsible Party _____ Date _____

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Initial Eye Exam History

Date ____ / ____ / _____

1) What have you/your veterinarian noticed wrong with your pet's eyes and/or vision?

_____

_____

2) How long have these changes been present? _____

3) Are you currently administering any eye medication? If yes, please list them. Yes ☐ No ☐

_____

_____

4) Does your pet have any other health problems?

Hormonal Disease (e.g. Cushings)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Urinary Tract Disease	☐ Yes	☐ No
Liver or Pancreatic Disease	☐ Yes	☐ No
Gastrointesinal Disease	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Nervous System Disease (e.g. seizures)	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No

5) If your pet plays with toys, does he/she violently shake his/her head during play? ☐ Yes ☐ No

6) Are you currently administering any non-eye related medications? ☐ Yes ☐ No

_____

7) Does your pet receive arthritis medication? (e.g. Rimadyl/Carprofen/Metacam/Galliprant) ☐ Yes ☐ No

_____

8) Does your pet receive allergy medication? ☐ Yes ☐ No steroidal or non-steroidal?

_____

9) Does your pet receive any pain medication? (e.g. Tramadol, Gabapentin) ☐ Yes ☐ No

_____

10) Has your pet traveled outside of state recently? ☐ Yes ☐ No

_____

11) Has your pet had any recent lab work performed? ☐ Yes ☐ No If yes, please indicate when/where.

_____

12) Has your pet had any other diagnostic tests performed? ☐ Yes ☐ No If yes, please indicate when/where.

_____

Our doctors will be very close to your pet's face during the examination. Please, for safety reasons, notify us if you believe your pet may require a muzzle *prior* to examining. If your pet DOES NOT require a muzzle, please initial in the space below.

Muzzle? ☐ Yes ☐ No If no, please initial here: _____