PATIENT AND OWNER INFORMATION

Patient Name:_____________________ Owner's Last Name:____________________________________
Breed:_________________________ Owner's First Name:____________________________________
Species:_______________________ Spouse/Other Contact:__________________________________
Color:__________________________ Address:____
Please circle: Male **OR** Female City:_________________________ State:_____ Zip:_________
Is your pet Neutered/Spayed? _______ Place of Employment?__________________________________
Date of Birth (Or Age of Patient):_________ May we feature your pet on our social media pages? ___________

CONTACT INFORMATION

Primary Phone #:______________________ Spouse/Other Contact Primary #: ___________________________
SecondaryPhone #:____________________ Spouse/Other Contact Secondary#: _________________________

EMAIL INFORMATION

We will email you all of your medical records and receipt the day of your appointment. Please provide us with the best email address to send your information to:

Email Address:____

We try our best to remind you of your pets upcoming appointments. How would you prefer to receive this reminder? **Please select only one of the following options:**

- ❑ Please text me at :_______________________ My cell provider is:___________________________
- ❑ Please email me my appointment reminder at the email address I provided.
- ❑ Please continue to call me to remind me of my upcoming appointment.

VETERINARIAN INFORMATION

Referring Veterinarian:________________________________Hospital Name:_____________________________

MEDICAL INFORMATION

Problem with eye (please explain):____

____

Circle The Affected Eye: Right Left Both Duration of signs:____________________________________
Is your pet on any eye medications: Yes No If yes, please list them:________________________________

____

Has your pet had any problems/reactions with **ANY** Medications? Yes No
If yes, please list them:____
Has your pet been diagnosed with diabetes? YES NO
Does your pet have heart problems?___________________ Anesthesia problems?__________________________
Does your pet have any major health problems? If so please explain:______________________________________

____

Is your pet taking any other medications NOT related to the eye?____

____

HAS YOUR PET EVER NEEDED A MUZZLE DURING AN EXAM? Yes________ NO _________

Payment can be made by cash, check, Care Credit, and any major credit card. There is a $40.00 fee for all returned checks. Any delinquent account requiring legal action may be subject to a 33 1/3% attorney's fee in addition to all court costs. All appointments will include an exam fee (including follow up appointments).

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Signature:______________________________________ **Date:**____

Office Hours:

Monday through Thursday 8:30 AM to 4:30 PM

Friday 8:30 AM to 3:30 PM

Doctors' hours vary from office hours

- Animal Eye Care of Richmond is not a boarding facility, therefore **all** pets left for procedures/surgeries **must** be picked up by the close of business the day of the procedure.
- Follow up appointments and postoperative rechecks will have an examination fee unless the doctor tells you otherwise.
- Payment is due at the time of service. Unfortunately, we do not bill for services or medications.
- If your pet is not picked up by the close of business, we will transport your pet to the Veterinary Referral and Critical Care Center in Manakin Sabot and you will incur additional boarding, etc. fees.

Signature:____________________________ Date:___________

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