

# Animal Eye Clinic

## YOUR INFORMATION:

Last Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

First Name: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Street: \_\_\_\_\_ Spouse Cell: \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Other Numbers: \_\_\_\_\_

Your Date of Birth: \_\_\_\_\_ Driver's License: \_\_\_\_\_

\*\*Driver's License and Date of Birth are required if paying by check

## PET INFORMATION:

Pet's Name: \_\_\_\_\_ Color: \_\_\_\_\_

Breed: \_\_\_\_\_ Sex: \_\_\_\_\_

Age or Birth Date: \_\_\_\_\_ (Please estimate if actual age is unknown)

ANY HEALTH CONCERNS: (SUCH AS DIABETES,  
SEIZURES ETC.) \_\_\_\_\_ Current Weight \_\_\_\_\_

Referred by: \_\_\_\_\_ Veterinarian \_\_\_\_\_ Internet \_\_\_\_\_ Yellow Pages \_\_\_\_\_ other

Regular Veterinarian \_\_\_\_\_ Hospital/Clinic \_\_\_\_\_

*Please Read and Sign Below*

Payment is expected when services are rendered. We accept Cash, Check (ELECTRONIC CHECK), MasterCard, Visa, American Express, and Discover. Examination with Standard diagnostic tests is \$165.00. Medications and additional diagnostic testing are not included.

Your Signature: \_\_\_\_\_

I understand that payment is required at the time services are rendered.