Animal Eye Clinic
Arlington and Fort Worth

YOUR INFORMATION:

Last Name: ______________________

First Name: ______________________

Spouse: ______________________

Street: ______________________

City, State, Zip ______________________

Email Address: ______________________

Home Telephone: ____________________

Work Telephone: ____________________

Cellular Phone: ____________________

Spouse Cell: ____________________

Other Numbers: ____________________

How would you like to receive appointment reminders and other communications from our office?

TEXT   EMAIL   PHONE CALL

PET INFORMATION:

Pet's Name: ____________________

Breed: ______________________

Color: ______________________

Sex: ______________________

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

Any health concerns NOT EYE RELATED: (such as diabetes, seizures or heart condition(s)?)

____   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, 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.