



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 _____

Home Phone # () _____ Cell/Pager # () _____

Email Address _____ Drivers License (For Checks) _____

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 _____ 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 THE 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 _____