

New Patient Form

Animal Eye Care LLC

405 32nd St, Ste. 103, Bellingham WA 98225

Phone (360) 676-7770 Fax (360) 676-7776

Client and Pet Information:

If you are not the owner, what relationship are you to the owner: _____

Pet's Name: _____

Species: _____ Birthdate: _____

Last Name: _____

Breed: _____ Age: _____

Your First Name: _____

Color: _____ Weight: (please weigh

Occupation: _____

Sex: _____ your pet) _____ lbs

Partner/Spouse: _____

Neutered: YES NO

Occupation: _____

Phone:

Home: () _____

Address:

Street: _____

Cell: () _____

City: _____

Work/Other: () _____

State/Province: _____

Partner/Spouse: () _____

Zip/Postal Code: _____

Referral Information:

Veterinarian: _____

Hospital: _____

Veterinarian: _____

Hospital: _____

Who may we thank for referring your pet?

Name (if different from above): _____

Medical History:

Are there any medications or anesthetics that your pet is allergic to? If so, please list:

Animal Eye Care Financial Agreement and Consent:

- I understand that Animal Eye Care can only provide Ophthalmic Veterinary care
- I understand that full payment in US funds is required at the time of service. Canadian funds cannot be accepted.
- I understand that if I fail to show up for my appointments without at least 24 hours' notice, I will be charged a \$50.00 rescheduling fee, and if I fail to show up for 3 appointments, that my pet will no longer be accepted as a patient at Animal Eye Care.
- I understand that a \$40.00 service charge will be added to all NSF checks. All NSF checks not paid within 15 business days will be turned over to a collection agency and to the Whatcom County Prosecuting Attorney's office.

I plan to pay by: () Cash; () Check; () Debit; () Credit [VISA/MC/AmEx/Discover]

Signature

Date

You and your doctor will be provided with a report of your pet's ophthalmic examination.

NOTE: We will not examine vicious or aggressive animals or accept them as patients.