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: __________________________
Last Name: __________________________
Your First Name: ____________________
Occupation: __________________________
Partner/Spouse: ______________________
Occupation: __________________________

Species: ___________ Birthdate: __________
Breed: _____________________ Age: ______
Color: ________________ Weight: (*please weigh your pet*) ______ lbs
Sex: _________
Neutered: YES NO

Phone:

Home: (___)______________________
Cell: (___)______________________
Work/Other: (___)________________
Partner/Spouse: (___)______________

Address:

Street: ________________________________
City: __________________________________
State/Province: _______________
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.*