

Patient and Client Information Form

Animal Eye Care

Patient Information

Pet's Name..... Date of Birth..... Age.....

Canine Feline Other.....
 Male Male/Neutered Female Female/Spayed

Breed..... Color.....

Regular/ Referring Veterinarian.....

Client/Owner Information

Owner's Name.....

Address..... City..... Zip.....

Home Phone ()..... Work Phone ().....

Cell Phone ()..... e-mail.....

Driver's License #.....

Payment

Animal requires payment in full at the time of service. A 50% deposit will be required prior to treatment on emergency, surgical or in-patient services. The balance will be due in full upon the release of your pet. I/we fully understand the payment policy of Animal Eye Care and agree to take full financial responsibility for the pet listed.

Owner's Signature _____ Date _____

Co Owner's Signature _____ Date _____

Options available for payment are:

Cash Visa MasterCard Check