Keil Veterinary Ophthalmology

Client and Patient Information

Thank you for giving us the opportunity to care for your pet's ocular health.
Please fill this form out completely and legibly.

Date: _____

Owner Name: _____

Additional Contact Name (optional): _____Relationship to Owner_____

Owner Home Address: _____

City/State/Zip: _____

Barn Address (if applicable): _____

Primary Contact Information: Name: _____ Email Address: _____

Best # _____ this is: home work mobile Alternate # _____ this is: home work mobile

Additional Contact Information (optional): Name: _____ Email Address: _____

Best # _____ this is: home work mobile Alternate # _____ this is: home work mobile

Emergency Contact (optional): Name _____ Phone _____

How did you hear about our clinic? Your Veterinarian Our Website Facebook ACVO Website
Personal Recommendation (By whom? _____) Other: _____

Pet Name: _____ Please circle one: Cat Dog Horse Other_____

Breed: _____Birthdate/Age: _____Color:_____

Please circle appropriate: Male: Intact Neutered Gelding Female : Intact Spayed Pregnant

Is your pet current on all vaccinations: Yes No Uncertain **Horse: current on Coggins**: Yes No

Pet's Current Medications (including dose and frequency):

_____ _____ _____

_____ _____ _____

Pet's Diet: (kind of food and amount per day): _____

Travel History: Local _____ National/International _____

Primary Care Veterinarian #1:_____

Primary Care Veterinary Clinic / Hospital: _____

Primary Care Veterinarian #2 (if applicable):_____

Primary Care Veterinary Clinic / Hospital: _____

Medical Record Release: I authorize KVO to send all medical information of my pet to:

Primary care veterinarian #1	Yes	No
Primary care veterinarian #2	Yes	No

***Signature of Owner**: _____ **Date**: _____

Please review the following information. Your signature at the bottom of this form indicates that you have read and agree to each of the policies listed.

Cancellation Policy: To be courteous to other clients and the KVO staff, cancellations of any appointments or procedures must occur 24 hours prior to the appointment. Messages may be left after hours to notify KVO of changes. All missed appointments and appointments not cancelled in a timely fashion will be considered no-show appointments. **After two no-show appointments, and after any single surgery/procedure not cancelled 48 hours prior to the scheduled appointment, clients will be required to pre-pay to reserve their next appointment or procedure. This charge is non-refundable if the pre-paid appointment is missed or cancelled with less than 24 hours notice, or less than 48 hours notice in the case of surgeries and procedures.**

Prescription Refill Policy: Patients must be examined annually to legally authorize refill requests. Filled prescriptions may be picked up Monday, Tuesday and Thursday from 7:30AM to 5:00PM, Wednesday from 7:30 AM to 5:45 PM and Friday from 8:00AM to 12:00PM. Per Federal and State laws, any medication that has left the premises cannot be re-dispensed. **We are unable to accept returns or issue refunds on any medication that has been taken out of the clinic.**

Treatment Policy: By signing this form the owner authorizes the veterinarian to examine, treat, and/or prescribe medication for the animal described above. The owner assumes full responsibility for all charges incurred in the care of this animal.

Payment Policy: All charges are due in full when the animal is discharged. A minimum deposit of two-thirds of the estimated cost of services may be required prior to treatment. KVO accepts payment by cash, check, MasterCard®, Visa®, Discover®, American Express®. Returned checks will be assessed a $30 NSF fee in addition to the original face value of the check. This fee is separate from any bank charges incurred.

***Signature of Owner**: _____**Date**:_____

Susan M. Keil, DVM, MS, DACVO
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www.keileyevet.com

Ophthalmology History Form

Patient's Name: _____ **Date**: _____

(Please answer as completely as possible)

1. What eye problem do you (or your veterinarian) feel is affecting your pet?
   _____
2. When did the eye problem start? _____
3. Has your pet had eye problems in the past? Please explain: _____
   _____
4. Which eye is affected? Left Right Both
5. Any known toxin exposure or trauma? Yes No Unknown
   If yes, please explain: _____
6. Is the problem occasional or continuous? _____
   _____
7. Has the problem improved, worsened, or stayed the same in the last days/week?
   _____
8. If there is discharge from the eye please describe it and note how often you clean the eyes:
   _____
9. Is the eye painful (eye shut, pet crying)? Yes No Unknown
10. Is the eye itchy (rubbing at eye)? Yes No Unknown
11. Is your pet blind? Yes (if yes, **sudden** or **slow** loss?) No Unknown
12. Does your pet do better in light or dim settings? With moving or stationary objects? With near or far objects? _____
13. Please list all health problems of your pet: _____
    _____
14. Please list any eye problems of animals related to your pet: _____
    _____

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