

# Keil Veterinary phthalmology

## 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: \_\_\_\_\_

Home Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Phone # to contact you about your pet: \_\_\_\_\_

Alternate Phone # (optional): \_\_\_\_\_ Email Address: \_\_\_\_\_

**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** \_\_\_\_\_

Primary Care Veterinary Clinic / Hospital: \_\_\_\_\_

Other veterinarian(s) involved in your pet's care: \_\_\_\_\_

By signing below, I authorize KVO to send and receive all medical information concerning my pet.

\*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/Late Arrival Policy:** To be courteous to other clients and the KVO staff, cancellations of any appointments or procedures must occur 48 clinic hours prior to the appointment. Messages may be left after hours to notify KVO of changes. All missed appointments and appointments not canceled in a timely fashion will be considered no-show appointments. Arriving late for an appointment negatively impacts others' schedules. Five minutes after the scheduled appointment time is considered late. Late arrivals may experience significant wait times, as clients arriving on time will be seen first, or may be required to reschedule. **After two no-show or late arrival appointments, and after any single surgery/procedure not canceled 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.** Thank you for your understanding.

**Prescription Refill Policy:** Patients must be examined annually to legally authorize refill requests. Filled prescriptions may be picked up Monday – Thursday from 7:30a.m. to 5:00p.m. and Friday from 8:00a.m. to 12:00p.m. excluding holidays. 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®, and CareCredit®. 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.

Thank you for choosing Keil Veterinary Ophthalmology for the care of your pet.

\*Signature of Owner: \_\_\_\_\_ Date: \_\_\_\_\_

**Susan M. Keil, DVM, MS, DACVO**

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[www.keilleyvet.com](http://www.keilleyvet.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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