

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

Best number to contact you about your pet: \_\_\_\_\_ this is: home cell work

Alternate contact number for owner (if available): \_\_\_\_\_ this is: home cell work

Email Address: \_\_\_\_\_

Optional alternate contact person: (spouse/family/other) 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  
For cats only: vaccinated for FeLV/FIV Yes No    If yes, date vaccinated \_\_\_\_\_

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.**

**Prescription Refill Policy:** Patients must be examined every 365 days for us to legally authorize prescription refill requests. Filled prescriptions may be picked up Monday – Thursday 7:30 am – 5:00 pm and Friday 8:00 am – 12:00 pm excluding holidays. Per federal and state laws, any medication that has left the premises cannot be re-dispensed. **We are unable to issue refunds on any prescription medication(s) that has left the parking lot.** You are responsible for knowing the name and quantity of the medication(s) you need. Please, also double check your order before you depart the clinic. **Bring your medications with you to your appointment so you can determine your current stock.** If in doubt and/or if you feel you may have the medication already at home, please refrain from ordering without checking. Medications can and will be accepted back without refund to you if you no longer need medications and wish to have them DONATED to shelters and rescue groups (these meds are not resold).

**Cancellation / Late Arrival Policy:** KVO will no longer be absorbing the daily late arrivals and no-show appointments which negatively impact our receiving schedule.

New patient consultations are reserved with full pre-payment at the time the appointment is made. Reservations will be 100% refunded if the appointment is canceled/changed with adequate notice. **Without exception, if you make changes to, cancel, forget, or arrive late to a new patient appointment without adequate notice (48 working hours\*\* prior to your appointment), you will forfeit the \$204 consultation fee.** If you wish to reschedule, a second reservation payment will be collected at the time of scheduling.

Returning patients who miss a recheck, procedure, or surgery will not be charged for their missed appointment, however, they will be required to reserve their next time slot with pre-payment (base recheck fee, or ½ of a procedure/surgical estimate).

**Without exception, if you make changes to or cancel that pre-paid appointment without adequate notice (48 working hours\*\* prior to your appointment), you will forfeit the pre-paid amount.** If you wish to reschedule, another reservation payment will be collected at the time of scheduling.

**Note: arrive 15 minutes prior to your appointment time. If you elect to arrive more than 5 minutes after your scheduled appointment, you will be asked to reschedule and reserve the next available time slot with pre-payment.**

\*\*We see patients Monday through Thursday 7:30-5. The clinic is open Friday 8-12 and has a phone system for leaving messages.

Changes to Monday appointments will need to occur no later than the scheduled time the Thursday prior to the appointment.

Changes to Tuesday appointments will need to occur no later than the Friday prior to the appointment.

Changes to Wednesday appointments will need to occur no later than the scheduled time Monday of the same week.

Changes to Thursday appointments will need to occur no later than the scheduled time Tuesday of the same week.

These timelines allow us to reach out to clients on our wait list and re-organize our surgeries and procedures for other patients.

**Treatment Policy:** Owner authorizes examination of and treatment for the animal described and assumes full responsibility for all charges incurred. All charges are due in full when your pet is discharged.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 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 your pet blind?    Yes (if yes, sudden or slow loss?)    No    Unknown
11. Does your pet do better in light or dim settings? With moving or stationary objects? With near or far objects? \_\_\_\_\_
12. Please list all health problems of your pet: \_\_\_\_\_  
\_\_\_\_\_
13. Please list any eye problems of animals related to your pet: \_\_\_\_\_
14. For cat patients only:    Indoor only    Supervised outdoor    Unsupervised outdoor    Indoor/Outdoor  
Tested for FeLV (leukemia)?    Yes or No    If yes: Positive or Negative    Date of test \_\_\_\_\_  
Tested for FIV (kitty AIDS)?    Yes or No    If yes: Positive or Negative    Date of test \_\_\_\_\_

Current Medications:

Please provide a complete list of any medication your pet is currently on, including the exact dose you give, the frequency with which you give it, when you started giving the medication, and what it is being used for. It is important that you complete this to avoid delay and/or confusion at your appointment. We may not have received records from your primary care veterinarian prior to your appointment, or they may not include all the details requested below.

**For dog owners:** Many eye diseases benefit from the use of oral NSAIDs (Rimadyl, Deramaxx, Metacam, Galliprant) or steroid (prednisone). Be sure to inform Dr. Keil/KVO staff if your dog has kidney and/or liver disease and/or if your dog is on an oral steroid or NSAID. The choice/dose of an oral NSAID/steroid is very influenced by your response.

**For all owners:** If you are administering CBD in any form, inform us as to the dose/duration. Laboratory values, anesthesia drugs and/or pharmaceuticals can be affected by these products.

**If you have additional medications you need to list, please print off a second form.**

1. Medication name and date started: \_\_\_\_\_

Dose and Frequency: \_\_\_\_\_

Why you are giving it: \_\_\_\_\_

2. Medication name and date started: \_\_\_\_\_

Dose and Frequency: \_\_\_\_\_

Why you are giving it: \_\_\_\_\_

3. Medication name and date started: \_\_\_\_\_

Dose and Frequency: \_\_\_\_\_

Why you are giving it: \_\_\_\_\_

4. Medication name and date started: \_\_\_\_\_

Dose and Frequency: \_\_\_\_\_

Why you are giving it: \_\_\_\_\_

Past Medications:

Are there any medications your pet has been on in the past that you still currently have, but are not using?  
If so, please list below:

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