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: _____

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 entire 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 7:15a-5p. 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.

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 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:

_____

_____

Which eye?

Because people often get confused when answering this question, pretend you are your pet, looking the same direction they are, when you think about which eye is affected. Left, right, or both. If you have questions, please ask.

Consent to Treat:

I, the undersigned, do hereby certify that I am over the age of 18 and am the owner (or authorized agent) of the above-described patient. I authorize Keil Veterinary Ophthalmology (and its employees, affiliates, agents and contractors) to receive, examine, prescribe and treat the above-described pet. I further understand that no guarantee of successful treatment is made and I will not hold Keil Veterinary Ophthalmology (or its employees, affiliates, agents, or contractors) responsible for my pet's recovery.

Signature: _____ Date:_____