Welcome to the ANIMAL EYE CARE CLINICS

1221-B Avenida Acaso Camarillo, CA 93012

PLEASE CIRCLE: Mr. Mrs. Ms. Miss Dr. Other_____

_____ _____

Owner's First Name Owner's Last Name

Home Phone: (_____) _____- _____

Daytime Phone: (_____) _____- _____

Cell Phone: (_____) _____- _____

Email: _____

PLEASE CIRCLE: Mr. Mrs. Ms. Miss Dr. Other_____

_____ _____

Co-owner's First Name Co-owner's Last Name

Home Phone: (_____) _____- _____

Daytime Phone: (_____) _____- _____

Cell Phone: (_____) _____- _____

Email: _____

Owner's Street Address: _____

City:_____ State: _____ Zip: _____

Employer: _____ Position: _____

Driver's License #: _____ State: _____ (For identification purposes only, this information will be kept confidential.)

Name of regular veterinarian:_____ Clinic Name:_____

Pet's Name: _____ Dog Cat **Other:** _____

PLEASE CIRCLE: Male Neutered Male Female Spayed Female Unknown

Breed:_____ Date of Birth: _____ or Age: _____

Has your pet been vaccinated within the past 12 months? ☐ YES ☐ NO

Has your pet been vaccinated for Rabies in the last 3 years? ☐ YES ☐ NO

Does your pet have any known drug allergies or reactions? ☐ YES ☐ NO

(Please specify): _____

PLEASE ANSWER THE FOLLOWING QUESTIONS. (IF NONE, PLEASE STATE 'NONE')

What eye problem (s) is your pet currently having?_____

What previous eye problem(s) has your pet had? _____

What other medical problems does your pet have? _____

PLEASE LIST ANY OTHER MEDICATIONS YOUR PET IS BEING TREATED WITH:

Eye medications: _____

Oral medications: _____

ANY other medications, supplements or special diet: _____

*1) I, the undersigned owner, or owner's agent have the sole and exclusive right to seek veterinary care for the pet identified above, certify that all of the above information is correct, that **I AM** over eighteen years of age, and hereby consent to the examination of this pet by staff veterinarians at the Animal Eye Care Clinics. I also agree that after consultation with me, the hospital veterinarians may prescribe medication for, treat, hospitalize, sedate, anesthetize, and/or perform surgery on this animal.*

2) I have received a copy of the Animal Eye Care Clinic-Our Practice Policies and agree to abide by these policies.

Signature of owner: _____ Date:_____

Revised 07/2015

Processing Staff Member Initials: _____