



Please complete the following information...

Owner's Last Name: \_\_\_\_\_
Owner's First Name: \_\_\_\_\_
Spouse's First Name: \_\_\_\_\_
Home Phone: \_\_\_\_\_
Street: \_\_\_\_\_
Employer: \_\_\_\_\_
Spouse's Employer: \_\_\_\_\_
Discharge and Receipt Preference:  Email  Print
Pet's Name: \_\_\_\_\_
Age or Birth Date: \_\_\_\_\_
Referring Veterinarian: \_\_\_\_\_
Alternate Veterinarian: \_\_\_\_\_
Your Cell: \_\_\_\_\_
Cell Carrier: \_\_\_\_\_
Spouse's Cell: \_\_\_\_\_
Cell Carrier: \_\_\_\_\_
Email: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Work Phone: \_\_\_\_\_
Work Phone: \_\_\_\_\_
Appointment Confirmation Preference:  Email  Text
Breed: \_\_\_\_\_ Color: \_\_\_\_\_
Sex:  Male  Neutered Male  Female  Spayed Female
Hospital: \_\_\_\_\_
Hospital: \_\_\_\_\_

Please let us know the changes you have observed regarding your Pet's eyes...

1. Which eye(s) have you noticed having problems?  Right  Left  Both
2. What changes did you observe? \_\_\_\_\_
3. How long have the change(s) been present? \_\_\_\_\_
4. Has your pet received therapy/medications for this problem? If so, please list these medications: \_\_\_\_\_

Payment is due at the time of service. Accepted forms of payment include cash, debit card, Mastercard, Visa, Discover, and American Express. Should this account default and is referred to an attorney for collection, then I agree to pay all collection costs, including attorney fees up to 40% of the principal amount due and owing when turned over for collection. I also agree to pay interest on the unpaid balance at the rate of 1.5% per month (18% per annum) from the date that said monies become due and payable.

\_\_\_\_ I understand the payment policy.

At least 24 hours of notice is expected for cancellations. I understand that if I no-show or cancel with less than 24 hours notice, I may be required to pay a non-refundable deposit in the amount of the initial exam fee cost in order to reschedule to the next available appointment.

\_\_\_\_ I understand the cancellation policy.

I authorize VECO to use photos and medical information of my animal for educational and promotional purposes through continuing education seminars for veterinarians, its website, and social media outlets. I understand that my consent is strictly voluntary and that my pets name and my personal information will NOT be shared.

I agree and authorize  I do NOT agree nor authorize

By signing below, I authorize that I am over eighteen years of age and I authorize Veterinary Eye Center of Oklahoma (VECO) and its employees to assess and treat my animal listed above, and I agree to pay all associated fees with these services.

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