OWNER INFORMATION **Date:** _____

Name: _____
Last *First* *M.I*

Address: _____
Street *Apt #*

_____
City *State* *Zip*

Home #:_____ Cell #:_____ Work #:_____

Employer: _____ Occupation: _____

Preferred Contact Method - Home Phone: ☐ Cell Phone: ☐ Work Phone: ☐

ALTERNATIVE CONTACT / CO-OWNER (*In case you cannot be reached)*

Name: _____
Last *First* *M.I*

Best Contact Phone #: _____ Relationship to Owner: _____

PET INFORMATION

Name: _____ Species - Dog: ☐ Cat: ☐ Horse: ☐ Other: ☐

Sex - Male: ☐ Female: ☐ Neutered/Spayed? **YES** or **NO**

Breed: _____ Color: _____ DOB/Age: _____ Weight: _____

PAYMENT
Charges for professional fees and dispensed medications are due at the time services/medications are rendered.
We accept: Cash, Visa, MasterCard, Discover, American Express and Care Credit. We cannot accept checks.

AUTHORIZATION
I hear by authorize Dr. Todd Hammond to examine, prescribe for, and/or treat my pet/patient. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time professional services are rendered and that a deposit may be required for any procedures and/or surgeries performed.

Signature of Owner/Agent/Guardian: _____

•PLEASE COMPLETE MEDICAL HISTORY ON THE NEXT PAGE•

---FOR OFFICE USE ONLY ---

Referring Veterinarian: _____ Phone #: _____
Referring Hospital: _____ Fax #: _____

No.	Date Active	Date Resolved	Master Problem

OWNER NAME: _____ **PET/PATIENT NAME:** _____

Does your pet require a muzzle or any special handling technique? Yes: ☐ No: ☐

If yes, please describe: _____

Please check off any present symptoms/conditions and when you first noticed the condition(s):

	Patient's ***LEFT*** eye	Patient's ***RIGHT*** eye	When did you first notice symptom(s)?
Swelling	☐	☐	
Discharge	☐	☐	If yes, what color?
Squinting	☐	☐	
Color change	☐	☐	If yes, what color?
Redness	☐	☐	
Cloudiness	☐	☐	
Enlarged eye	☐	☐	
Rubbing at eye	☐	☐	
Bleeding	☐	☐	
Blindness	☐	☐	
Other	☐	☐	Please describe:

	YES	**NO**	If yes, when did you first notice?
Changes in eating	☐	☐	
Changes in water intake	☐	☐	
Vomiting	☐	☐	
Diarrhea	☐	☐	
Changes in behavior	☐	☐	
Vaccine Reactions	☐	☐	
Allergies	☐	☐	To what?
History of seizures	☐	☐	

Has your pet ever lived or visited any place other than Colorado? This would include other states and/or countries.

_____

_____

_____

Current illnesses that your pet has:

_____

_____

_____

Previous Surgeries your pet has had:

_____

_____

_____

During these procedures were there any complications or abnormal reactions? Yes: ☐ No: ☐

If yes, please describe:

_____

_____

_____

Please list ALL medications you pet is currently taking, including heartworm preventative and vitamins/minerals and/or supplements such as glucosamine, etc. Please include the frequency administered, dosage (mg or other concentration) and which eye(s) if appropriate.

(Example: 10mg Prednisone 2 times per day, Optimune Ointment 2 times per day into both eyes.)

1:_____

2:_____

3:_____

4:_____

5:_____