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New Patient Form

Please fill out the information below. We can't wait to meet you and your best friend!

This is all about you

Your Name: _____

Alternate Contact:_____

Address: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Alternate Contact Phone Number: _____

What is the best number to reach you on?
Home
Cell

What is the best way to contact you regarding upcoming appointments?
Email
Text

Tell us about your best friend:

Name: _____

Species: _____

Breed: _____

Weight:_____ pounds

Sex: Male / Female Castrated / Spayed

Date of Birth: _____

Color: _____

Which eye is affected?
Right
Left
Both

What is the problem your pet needs evaluated at this appointment?
Loss of Vision
Eye Discharge
Squinting (holding the eye shut)
Change in color or cloudiness
I'm not sure my veterinarian noticed the problem and recommended I see an ophthalmologist
Other
_____
_____

How long has this problem been present?
_____

Has the problem changed since you first became aware of it?
Improved
Worsened
Unchanged

Is your pet's eyesight:
Excellent
Fair
Poor on occasions
Poor in dim/dark lighting conditions
Poor in full sun/bright lighting conditions
Poor with objects nearby
Poor with objects far away

Has your pet had other eye problems in the past?
Yes
No

Please list the other medical conditions you pet may have (ie: diabetes, hypertension, Cushing's disease, etc…)
_____
_____
_____

What medications is your pet on?

Medication	Strength (mg)	Use instructions	What time do you administer the medication?

Who is your primary care veterinarian so we can keep them updated with your pets progress
Dr. _____

Clinic Name: _____ Clinic Phone:_____

Bluegrass Veterinary Vision would love to share your pets picture/name on social media. **Please note-we will never use pet parents names**
Yes, please share
No thank you

Permission to Treat/Veterinarian Authorization/Payment Policy

I certify that I am the owner or authorized agent for the patient described above and have the ability to give you my permission to receive, prescribe for, treat as is necessary, perform procedures therapeutically and/or diagnostically and/or operate upon my pet. I grant my permission for the release of any or all of the information contained in the medical records of the patient described above to any inquiring parties. I acknowledge that the use of general anesthesia or sedation is associated with certain risks which could include serious injury or death to the above described animal. Anesthesia or sedation would not be performed without your specific consent. I further understand that no guarantee of successful treatment is made.

Payment for all Services Provided Due at the Time of Service

Please review the invoice upon receipt and tell us immediately if you believe it is incorrect.

We accept:
- Credit and Debit Cards-Visa, MasterCard, Discover, American Express, Care Credit
- Personal Check
- Cash
- Insurance Claims-You file and receive reimbursement from your insurance company.

Nonpayment and Future Services
If full payment is not received for all services within 1 week after services are rendered, we reserve the right to stop providing future goods and services until balance is paid in full. We may pursue any remedy permitted by law to collect amounts owing, including collection costs, court costs, and reasonable attorney fees.

Returned Check and Reversed Credit Card Payment Policy
If a check is returned, we have the privilege to revoke the right for you to use a check as payment again. We may revoke the use of a credit card again if a charge is reversed without cause attributable to us. We will pursue collection of all checks returned for insufficient funds. Accounts forwarded to collections will be assessed all applicable collection and attorney costs.

You waive presentment and notice upon dishonor of any check presented for payment. If your check is returned to us for insufficient funds, you will pay (a) a returned check fee, and (b) all of our costs of collection of the check, including but not limited to dishonored check charges imposed by law by our bank, court costs and reasonable attorney fees. We may pursue any remedy permitted by law to collect these amounts.

Acceptance of partial or late payments, restricted payments other than in cash or US currency shall not waive our rights and remedies under law.

WARNING!
All accounts with an outstanding balance five business days after services rendered may be forwarded to a third party collection agency. When requesting our services, you are responsible for any fees charges by the collection agency. Delinquent account information may be reported to national credit reporting agencies by the collection agency.

Client agreement and Authorization
By signing below, you agree to the terms of this Bluegrass Veterinary Vision policy. This payment policy contains the entire understanding with respect to payment and collection charges, and replaces all prior understandings, promises, and representations, whether written or oral, relating thereto. You authorize us and our collection agency to obtain your credit report if we elect to enforce our remedies upon non-payment of fees for services.

_____ _____
Client Signature Date

_____
Client Name (Please print)