

Animal Eye Associates, P.A.  
Dr. Daniel R. Priehs, D.V.M.  
Dr. Heidi M. Denis, D.V.M.  
9901 Highway 17/92  
Maitland, Florida 32751  
(407)629-0044 ext. 1

Welcome to Animal Eye Associates. So we may become more familiar with you and your pet, please fill out the following form.

STANDARD CONSENT & CLIENT INFORMATION

OWNER'S NAME: \_\_\_\_\_

SPOUSE/OTHER: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

OWNER'S EMPLOYER: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

REFERRING VETERINARIAN: \_\_\_\_\_ CLINIC NAME: \_\_\_\_\_

ANIMAL INFORMATION

PET NAME: \_\_\_\_\_ DOG ( ) CAT ( ) OTHER: ( ) BREED: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ COLOR: \_\_\_\_\_ SEX: \_\_\_\_\_ ALTERED \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

HAS YOUR PET HAD A SEIZURE BEFORE? \_\_\_\_\_ WHEN: \_\_\_\_\_

PLEASE LIST ANY MEDICAL CONDITIONS OR ALLERGIES/REACTIONS:

\_\_\_\_\_

**PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED  
THERE IS NO BILLING SERVICE**

**FORM OF PAYMENT DESIRED**

CASH (\_\_\_) CHECK (\_\_\_) VISA (\_\_\_) MASTERCARD (\_\_\_) DISCOVER(\_\_\_)

I am the owner of the above pet, or am acting as an agent for the owner, and accept full financial responsibility. I give permission to proceed for any medical/or surgical therapy as needed as discussed and agreed upon with the doctor.

**DRIVER'S LICENSE NUMBER:** \_\_\_\_\_

**SS#:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_