



ANIMAL EYE CLINIC
Board Certified Ophthalmologists

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Fees charged reflect the quality and value of our advanced and specialized medical and surgical services. They reflect the degree of expertise required to diagnose and treat your pet, as well as the cost of the diagnostic, therapeutic, and surgical equipment utilized. Written estimates are provided for patients for which surgery and/or advanced diagnostic procedures under sedation or general anesthesia are recommended. Fees are payable in full when services are provided, in the form of a major credit card (Visa, MasterCard, Discover, or American Express), a debit card, a check or cash.

DATE: _____ PET'S NAME: _____

OWNER NAME: _____

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (home) _____ (work) _____ (mobile) _____

EMAIL: _____

REFERRING CLINIC & VET: _____

REFERRING CLINIC FAX: _____ PHONE: _____

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ABOUT YOUR PET:

BREED: _____ COLOR: _____ AGE: _____ SEX: _____

SPAYED/NEUTERED? _____ WEIGHT: _____ DIABETIC? _____ IMMUNIZATIONS CURRENT? _____

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PLEASE LET US KNOW THE CHANGES YOU'VE OBSERVED REGARDING YOUR PET'S EYES:

1. WHICH EYE(S) HAVE YOU NOTICED HAVING PROBLEMS? _____

2. WHAT CHANGES DID YOU OBSERVE? _____

3. HOW LONG HAVE THE CHANGES BEEN PRESENT? _____

4. HAS YOUR PET RECEIVED THERAPY/MEDICATIONS FOR THIS PROBLEM? IF SO, PLEASE LIST THEM:

5. DID ANY OF THESE TREATMENTS HELP? IF SO, PLEASE LIST THEM: _____

6. OTHER HEALTH CONDITIONS/MEDICATIONS? _____