VCA Eye Clinic for Animals
5610 Kearny Mesa Rd Suite A
San Diego Ca, 92111
Phone 858-502-1277
Fax 858-502-1340

Owner Information

Last Name _____ First Name _____

Spouse_____

Address _____

City _____ Zip _____

Phone Home _____ Work _____ Cell _____

DL#_____ Email _____

Patient Information

Horse's Name _____ Sex _____ Age _____ Color _____

Breed _____

Who is your horses Primary Care Veterinarian? _____

Hospital Name _____

Are there any known medical conditions or allergies? Yes No

If yes, please briefly describe _____

I UNDERSTAND PAYMENT IN FULL IS REQUIRED AT TIME SERVICES ARE RENDERED AND THAT THE $475 EXAMINATION IS FOR THE INITIAL EXAMINATION ONLY, AND IS DUE AT THE TIME THE APPOINTMENT IS MADE. ADDITIONAL FEES MAY BE RENDERED AT THE TIME OF EXAM FOR ADDITIONAL TESTING, TREATMENTS, SEDATION OR MEDICATIONS. IF SURGERY IS RECOMMENDED A DEPOSIT OF THE LOW END OF THE ESTIMATE WILL BE REQUIRED PRIOR TO THE PROCEDURE BEING PREFORMED. PLEASE NO PERSONAL CHECKS will be accepted _____ initial

Owner Signature _____ Date _____(Cash, Visa, MasterCard, Discover, Care Credit, and American Express only)

Informed Consent

I hereby authorize VCA Eye Clinic for Animals to perform Medical Care for my horse(s) as deemed necessary by the Veterinarian. I understand that No Guarantee can be given to the outcome of medical treatments or surgeries.

Owner Signature _____ Date _____

Jamie Schorling, DVM, MS
Dean Vestre, DVM, MS
Jane Ashley Stuckey, DVM, MS

Diplomates, American College of Veterinary Ophthalmologists

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VCA Photo Release Authorization Form

I, _____, hereby give my permission for any and all usage of my name, image, likeness, and recording hereof and my pet's image to appear in VCA and its affiliates video, brochures, advertisements, and any and all other media. This permission extends to all future usage and printings

I also understand that there will be NO compensation from VCA and its affiliates for the use of the photograph(s) now and in the future. I will make no monetary or other claim against VCA, Inc., or any of its affiliates for the use of the interview and/or the photograph(s)/video.

Signature: _____

Date:

Patient Name:

Hospital AU 998

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