



**ANIMAL EYE MEDICAL & SURGICAL SPECIALISTS**

6356 S Peek Rd, Ste 100, Katy, TX 77450  
(832) 437-0119 Phone (832) 437-0211 Fax

**CLIENT INFORMATION**

Owner Name: \_\_\_\_\_ Partner's Name: \_\_\_\_\_

TX Drivers License #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

We must be able to reach you. Please provide us any number that will allow us to contact you or another responsible party. Thank you!

**PATIENT INFORMATION**

Dog  Cat Name: \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Male  Neutered Male  Female  Spayed Female Age: \_\_\_\_\_ Yrs \_\_\_\_\_ Mths

Your Regular Veterinarian: \_\_\_\_\_

Reason for visit/eye concern: \_\_\_\_\_

Please list any other health problems: \_\_\_\_\_

**\*\*\*The consult fee is \$200.00**

Full payment is expected when the patient is released from the hospital. **A DEPOSIT EQUAL TO THE LOW END OF THE ESTIMATED CHARGES IS REQUIRED PRIOR TO SURGERY.**