



Patient Intake Form

Client Information

To help us provide the best care, please complete the following: (please print)

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Owner First and Last Name(s) _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone(s) _____

Cell Phone(s) _____

Fax _____ E-Mail _____

Employer _____

Who referred you to Rocky Mountain Veterinary Neurology? _____

Name of your PRIMARY Veterinarian / Hospital _____

Patient Information

Your pet's Name / Nickname _____ Species: Canine Feline Other _____

Breed _____ Sex: Male Female Male Neutered Female Spayed

Your pet's Birth date or Age _____ How long have you owned your pet? _____

Patient Medical History

Current medications and dosages _____

When were medications last given? _____

Has your pet had unusual/unexpected reactions to medications or vaccines? Yes No

• If yes, what did your pet react to? _____

Is your pet now taking preventative for heartworm disease? Yes No

• If yes, what is the name of the medication? _____

Date of last vaccination _____

Why are you presenting your pet for neurologic consultation today? _____

What are your pet's clinical symptoms? _____

When did you first notice these symptoms? _____

Is your pet getting: Better Worse The Same

Do you keep your pet(s) Indoors Outdoors

Has your pet traveled out of Colorado? Yes No If yes, where and when? _____

Patient Medical History

Has your pet been treated for any major medical problems? Yes No

• If yes, what type and when? _____

Has your pet ever undergone any type of surgery, other than neutering? Yes No

• If yes, what type of surgery and when? _____

Has your pet lost or gained weight recently? Yes No If yes: Gained Weight Lost Weight

• Approximately how much weight? _____ Over what time period? _____

What type of food do you currently feed your pet? _____ How much? _____ How often? _____

When is the last time your pet has eaten? _____

Has your pet's water intake changed? More Less No Change

Has your pet's urinary habits changed? More Less No Change

Has your pet experienced seizures? Yes No

• If yes, when was the first seizure? _____ When was the last seizure? _____

When were serum levels last tested? _____

TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE

I hereby authorize VRCC practices to perform medical and initial diagnostic/surgical procedures on this animal as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors and assistants.

If you were referred to our hospital by another veterinarian, they will require a summary of your pet's care and treatment in order for your pet's care to continue without interruptions. VRCC considers that your identification of a referring veterinarian implies your authorization to release records and information to that referring veterinarian.

We are leaders and teachers in the veterinary medicine field, thus case information and/or photos may be used in teaching, forms continuing education, web site, veterinary literature, and the like. I authorize the release of case/patient information for such purposes.

By submitting any photo to RMVN, you agree to the following:

I certify that I am 18 years of age or older, and I am the sole owner of the photograph(s) I submit to RMVN. I agree not to email any photograph(s) protected by copyright without the express permission of the owner of the copyright. I grant RMVN the right to reproduce, distribute, publish, display, edit, modify, create derivative works and otherwise use the photograph(s) for any purpose in any form and in any media. I agree to indemnify RMVN for all damages and expenses that may be incurred in connection with the photograph(s), including but not limited to the publication of the photographs on <http://rockymountainveterinaryneurology.com> and to use my name in connection therewith if Rocky Mountain Veterinary Neurology, LLC so chooses.

In the event that I sell this animal to another owner, I authorize release of medical information to the new owner.

FINANCIAL POLICY

Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance. The balance is due upon discharge from the hospital. You may pay by cash, personal check (with proper identification), accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.

In the event that payment is not made at the time of service, it is our policy to apply a service charge to accounts with a balance over 30 days old. A service charge of \$3.00 per month and 1.5% of the outstanding balance will be charged to your account if not paid in full.

NAMES OF INDIVIDUALS AUTHORIZED TO PICK UP ANIMAL FROM VRCC:

Name: _____

Name: _____

I understand that the owner or agent is financially responsible to the applicable VRCC practices for all charges relating to this animal. I have read and agree to the treatment authorization. I have also read and accept the financial obligations.

Owner(s) Signature

Date