ROCKY MOUNTAIN VETERINARY NEUROLOGY®

Rocky Mountain Veterinary Neurology
3550 S. Jason Street • Englewood, CO 80110
email: neurology@vrcc.com • 303.874.2081

# Patient Intake Form

## Client Information

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



Owner First and Last Name(s) _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone(s) _____

Cell Phone(s) _____ E-Mail _____

How did you hear about us? *(check all that apply)*

☐ Website/Internet/Facebook ☐ Radio/TV ☐ Magazine/Newspaper ☐ Local Event ☐ Walk In
☐ Family/Friend ☐ Primary Veterinarian ☐ Previous visit to VRCC ☐ Other _____

Who referred you to Rocky Mountain Veterinary Neurology? _____

Name of your PRIMARY Veterinarian / Hospital _____

VRCC Practices Your Pet Has Visited:

## 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? _____

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## 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 I have been referred to this hospital by another veterinarian, I understand that they will require a summary of the care and treatment provided by the VRCC practices in order to ensure that my pet's care can be continued without interruption. I also understand that VRCC considers the identification of a primary/referring veterinarian by me to be my authorization to release records and information to that veterinarian.

As leaders and teachers in the Veterinary Medical field, the Specialists and staff of VRCC may use medical case information for teaching, developing forms, providing continuing education, website, veterinary literature development, social media updates, etc. I authorize the release of case/patient information for such purposes. Patient confidentiality (client names withheld) will be maintained.

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/facebook.com/rockymountainvet and to use my name in connection therewith if RMVN 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), or accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.

A service fee of $3.00 and 1.5% of the outstanding balance will be charge to your account monthly if not paid in full. If applicable, you will be responsible for any lawyer and/or collection agency expenses that may be incurred.

**NAMES OF INDIVIDUALS AUTHORIZED TO PICK UP YOUR PET 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 patient. I have read and agree to the treatment authorization. I have also read and accept the financial obligations.

_____ _____

Owner(s) Signature Date