



ANIMAL EYE CENTER OF NEW JERSEY
48 NOTCH ROAD
LITTLE FALLS, NJ 07424

NEW PATIENT FORM

Please fill out the following form prior to you and your pet's visit.
 New patients should arrive 15 minutes before scheduled appointment time.
 Bring all medications your pet is currently on with you to the appointment.

Owner's Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

Patient's Name: _____ **Species:** _____

Breed: _____ **Color:** _____

Sex: Male Female **Neutered/Spayed:** Yes No

Referring Veterinarian: _____

Please check all that apply:

- | | | | |
|---|-------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Pawing at eyes | <input type="checkbox"/> Tearing | <input type="checkbox"/> Squinting | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Decreased Vision | <input type="checkbox"/> Cloudy Eye | <input type="checkbox"/> Eye Ulcer | <input type="checkbox"/> Red Eye |
| <input type="checkbox"/> Eyelid Problem | <input type="checkbox"/> Blind | <input type="checkbox"/> Glaucoma | |

When did you first notice your pet's eye problem? _____

Is your pet allergic to any medications? Yes No

If yes, which ones? _____

Has your pet ever had a seizure? Yes No

If yes, when was the last one? _____

Please list all medications that your pet is currently taking (including non-ophthalmic meds): _____
