EYE CLINIC REGISTRATION (please print)

Owner's Name: ____

Address ____

Phone No: __________________ E-Mail Address _________________________

Animal's Registered/Call Name: ____

Registration Number: ________________ Tattoo or Chip #: _______________________

Breed: _________________________ Date of Birth _________________________
Day Month Year

Sex: _____ Colour: _______________ Date of Prev. Exam: _____________________
Day Month Year

PLEASE CHECK TYPE OF APPOINTMENT AND PREFERENCE OF TIME

TYPE 1 ______ TYPE 2 ______

Friday Morning 9:00 to 10:30 ______ 10:45 to 12:00 ________

Friday Afternoon 1:30 to 3:00 _____ 3:15 to 5:30 _______

Saturday Morning 8:30 to 10:00 ______ 10:15 to 11:45 ________

Saturday Afternoon 1:00 to 3:00 ___________ 3:15 to 5:00 ________

IMPORTANT NOTICE

Please note that the appointment time you will be given is for 15 to 20 minutes before the time at which you will get in to see the Specialist. Drops used to dilate the pupil take about that long

The organizers of the clinic and the owners of the premises where the clinic is held may not be held responsible for any loss or damage to persons attending or to their property.

TOTAL FEE ENCLOSED $______________ ________________________________
Signature of Owner or Agent