Apex Dog and Cat Dentistry, PC
Donald Beebe, DVM, Diplomate AVDC
Board Certified Specialist in Dentistry & Oral Surgery

Client Information

Primary Owner First Name	**Last Name**
Email (For Medical Record/Reminders)	
How did you hear about us? ❒ Family Veterinarian ❒ VRCC ❒ Friend -Name:	
❒ Website ❒ Other:	
Additional Owner First Name	**Last Name**
Additional Owner Email	
Address	
City **State** **Zip**	
Primary Phone: ( )	**Text Enabled?** _____ ❒ Home ❒ Mobile ❒ Work ❒ Fax
Secondary Phone: ( )	**Text Enabled?** _____ ❒ Home ❒ Mobile ❒ Work ❒ Fax
Additional Phone: ( )	**Text Enabled?** _____ ❒ Home ❒ Mobile ❒ Work ❒ Fax

TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE

I hereby authorize Dr. Beebe and Apex Dog and Cat Dentistry to examine, prescribe for, and treat my pet. I understand that they will receive a summary of the care provided in order to ensure that my pet's care can be continued without interruption. I also understand that the identification of a referring veterinarian by me to be my authorization to release records and information to that veterinarian. 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; patient confidentiality will be maintained.

FINANCIAL POLICY

Payment is due as services are rendered. For hospitalized cases, a deposit may be required in advance. The balance will be due upon discharge from the hospital. You may pay by cash, personal check (with proper identification), Care Credit, or accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory. In the event 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 fee of 2% of the outstanding balance will be charged to your account monthly if not paid in full. All returned checks will incur a charge of $25.00 and may be referred to the District Attorney for collection.

I understand that I (the owner or agent) am financially responsible) 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.

_____ _____

Signature Date

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Pet Information

Pet Name		**Last Name**	
Sex (Circle) Male Female		**Neutered/Spayed (Circle)?** Yes No	
Species (Circle) Dog Cat		**Breed**	
Please list the family veterinarian to whom you would like summary letters forwarded			
Hospital	**Veterinarian**		**Referred? ❒**
Please indicate the veterinarians we need to obtain records from			
Hospital	**Veterinarian**		**Referred? ❒**
Hospital	**Veterinarian**		**Referred? ❒**
Color	**Date of Birth or Approximate Age**		

Reason for your visit _____

_____

List of Major Medical Problems _____

_____

List of Medications/Doses/Frequency _____

_____

Allergies (food/medications) _____

Vaccinations up to date (Y/N) _____ Date of last blood work _____

History of dental problems/treatment_____

_____

Diet _____

Circle any of the dental related signs noted below.

BAD BREATH
DISCOLORED TEETH
LOOSE OR MOBILE TEETH
RED OR BLEEDING GUMS
FRACTURED OR BROKEN TEETH
FAILURE TO LOSE BABY TEETH
GROWTHS ON THE GUM OR TONGUE
RELUCTANCE TO CHEW HARD ITEMS

Other _____

Please circle the toys/treats provided.

KONGS	BONES	ROPE TOYS	TENNIS BALLS	GREENIES
NYLON BONES	RAWHIDES	FRISBEES	DOG BISCUITS	ICE CUBES
CAT TREATS	PLUSH/SQUEAKY	ELK ANTLERS	COW HOOVES	OTHER _____

Please indicate your pet's current dental home care and the frequency it is provided.

Pet Toothpaste/Brushing _____ Mouth Rinse _____ Dental Diet _____

Water Additive _____ Dental Chews _____ Other _____