

New Avian Patient History Sheet

Amount offered to bird each day _____ Amount bird eats each day _____

How is water offered: Cup _____ Water bottle _____ Recently added food or dietary changes: _____

What signs have you noticed regarding this bird and this incident: Circle all that apply

Diarrhea, blindness, vomiting, constipation, tail bobbing, breathing difficulty, perching difficulty, fainting, fluffed feathers, drooping or injured wings or legs, injury to eye/nostril/ear causing bleeding, bitten by other bird or pet, feather picking or feather loss, skin bleeding, lameness, change in personality, change in vocalization, change in stool consistency, change in appetite, excessive water consumption, coughing or hoarseness

Describe any additional symptoms: _____

What tests have this bird been given (circle all that apply): Psittacosis, psittacine beak & feather disease, polyomavirus, parasites. Other: _____

List vaccines the bird has been given with the date of given: _____

Has this bird been seen by another veterinarian? _____ When/Why? _____

Has this bird been dewormed? _____ What treatment was used? _____

Additional comments (your opinion regarding this illness/accident) _____

Client Disclaimer: We will need a copy of your driver's license for identification purposes. If you, at any time, use a check, we will need a copy of your license. Checks can not exceed \$50.00 on the first visit. We cannot accept post dated checks. Payment is expected at the time of service. Thank you.

We are committed to providing your pet(s) with the best possible care. In order to achieve our goals we need your assistance in understanding of our payment policy. Payment for our services is due at the time services are rendered. Returned checks are subject to a \$30.00 fee. Balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month. A charge of \$35.00 will be assessed for broken/missed appointments not cancelled with a minimum of 24 hour advanced notice. Please be thoughtful of other animals who may need to see the veterinarian if you will not be able to make your scheduled appointment. If you have pet insurance we will provide the information needed to submit your claim.

I hereby authorize Bayshore Animal Hospital to examine and/or administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper care for my pet. If it is determined that my pet requires further care, I understand that I may ask for an estimate of the probable fees. Should it be necessary to collect my account through an attorney or collection agency, I hereby agree to pay all costs for collection including attorney fees, collection costs and court fees.

Signature: _____ Date: _____

Printed Name: _____