Client – Patient Information

Owner Information:

Name: _____

Phone: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Horses Information:

Horse #1 Name: _____ Breed: _____

Color: _____ Age/DOB: _____ Mare ⬭ Gelding ⬭ Stallion ⬭

Horse Location: _____

Horse #2 Name: _____ Breed: _____

Color: _____ Age/DOB: _____ Mare ⬭ Gelding ⬭ Stallion ⬭

Horse Location : _____

•West Coast Equine Medicine requires a credit card to be on file for any and all treatment •

Name as it Appears on the Card: _____

Billing Address for Card: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____

Type: Visa ⬭ MasterCard ⬭ Discover ⬭ American Express ⬭ Care Credit ⬭

Expiration Date: _____ Card Identification Number: _____

•I understand that payment is expected & collected at time of service. I agree to pay for all veterinary services performed on my animal(s).

Signature: _____ Date: _____

AUTHORIZATION

I hereby authorize the Veterinarians and staff at West Coast Equine Medicine to examine, prescribe for, or treat the above animal(s) described. I assume responsibility for all charges incurred in the care of this animal(s). I also agree to the payment terms stated above and authorize West Coast Equine Medicine to charge the card on file for services rendered and also agree to pay for any and all collection fees and/or legal fees incurred on the above account. I understand I will be charged a full call fee for any scheduled appointment that is canceled within 1 business day of the scheduled appointment time.

Signature of Owner: _____ Date: _____