New Client Form

Registered Name (on coggins):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Barn Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance information (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Owner Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Owner Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Owner Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Barn Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Barn Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of PPID (Cushing’s disease)? Yes No

History of insulin resistance or equine metabolic syndrome? Yes No

Any pertinent medical history or medication reactions?

Reason for visit:

Name:

Horses name:

Phone number:

Email:

Please initial next to each line and sign and date at the bottom

* If my horse is insured, I understand that it is my responsibility, as the owner of the horse, to inform the insurance company of any medical procedure or claim in accordance with my policy.
* I give the veterinarian permission to examine my animal, administer any treatments, and preform procedures deemed necessary. A financial estimate for procedures and treatments will be provided upon request.
* I understand the most procedures and treatments done on my animal are not without some risk. Common procedures such as intravenous injections, intra-articular (joint) injections, and rectal palpation have a very low, but possible risk of complications. Complications that may occur from common procedure include, but are not limited to, intra-arterial injection, injoint infection, rectal tear, or medication reactions, I understand that these complications may result in serious disease or death of the patient.
* I release the veterinarians, farriers, East Coast Hoof and Wellness Center, and East Coast Farrier service of any and all liabilities.
* I understand that payment is due in full at time of service. Check, cash, or Venmo are accepted.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_