

Park Equine Hospital

Client Information

Name/Farm: _____

Address: _____

Primary phone: (cell) (home) (work) _____

Fax: _____

Other phone: (cell) (home) (work) _____

Owner (if applicable): _____

Owner address: _____

Owner phone: _____

Equine Information

Number of Horses: _____ Breed: _____

Name of Horses:	Age:	Sex:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Authorization

I hereby authorize the veterinarian to examine, prescribe and treat my horse(s), and I assume responsibility for all charges incurred. I also agree to pay any collection costs and reasonable attorney fees in the attempt to collect on this account.

Credit Card Information: # _____

Exp: _____ Pin _____

Signature: _____ Date: _____

Driver's License #/State: _____