



14099 Hwy. 62  
Eagle Point, OR 97524

www.rogueequine.com

phone (541) 826-9001  
fax (541) 826-1099

**CLIENT (CONSUMER) INFORMATION**

**Completion of this information in its entirety is required at time of service.**

**Legal Owner Name** \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

**Social Security#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **DL#** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Physical Address:** \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

**Mailing Address:** \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

**Home Telephone** (\_\_\_\_)\_\_\_\_ - \_\_\_\_ **Cell** (\_\_\_\_)\_\_\_\_ - \_\_\_\_ **Work** (\_\_\_\_)\_\_\_\_ - \_\_\_\_

**E-Mail Address:** \_\_\_\_\_

**Legal Spouse/Partner/ Leasee Information:**

*(If Contact information is the same as owner, please complete Name and Social Security ONLY)*

**Name** \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

**Social Security#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **DL#** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Physical Address:** \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

**Mailing Address:** \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

**Home Phone** (\_\_\_\_)\_\_\_\_ - \_\_\_\_ **Cell** (\_\_\_\_)\_\_\_\_ - \_\_\_\_ **Work** (\_\_\_\_)\_\_\_\_ - \_\_\_\_

**E-Mail Address:** \_\_\_\_\_

**Emergency Contact Information:**

\_\_\_\_\_  
Name Phone Cell#

\_\_\_\_\_  
Ranch, Farm, Stable Phone Location of Horse Phone

**Patient Information:**

Horse's Name	Breed	Sex	Color	Birth year	Discipline

PAYMENT FOR SERVICES EXPECTED AT TIME OF SERVICE.

If Payment is not made at the time of service, a 2% finance charge per month will be assessed to outstanding balances after 30days.

We understand that emergencies are unplanned and we offer Care Credit to qualifying clients that need to set up a payment plan.

Any account that is past 30 days is considered past due.

Owner  Lessee  Partner  is responsible for payment of all services rendered to horse(s) by Rogue Valley Equine Hospital, Inc. This includes any service requested by trainer/agent, or authorized caretaker.

I agree to all the above terms and conditions of Rogue Equine Hospital, Inc.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CREDIT CARD SIGNATUE ON FILE AUTHORIZATION:**

One time charge only

On file for future services  
(The office calls prior to running card)

Type of Card \_\_\_\_\_

\_\_\_\_\_  
Credit Card Number

\_\_\_\_\_  
EXP .DATE

\_\_\_\_\_  
3 Digit Code

\_\_\_\_\_  
NAME AS IT APPEARS ON CARD

\_\_\_\_\_  
BILLING ADDRESS THAT YOUR CREDIT CARD STATEMENT IS SENT AND ZIP CODE

I \_\_\_\_\_ authorize Rogue Equine Hospital to process the above credit card as "Signature on File" for equine veterinary services.

Please list all persons ***AUTHORIZED*** to charge equine veterinary services to this card. If there are no authorized persons, please put NA on line.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
SIGNATURE OF AUTHORIZED CARD HOLDER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHONE NUMBER

\_\_\_\_\_  
FAX NUMBER

Rogue Equine Hospital accepts most major credit cards and debit cards. If paying by credit or debit cards.

Please be assured that Rogue Equine Hospital keeps all personal information private.

If there are any changes in your information, please notify the office.  
Rogue Equine Hospital