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#_____State_____ExDate_____ Birth Date_____

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#_____State____ Ex Date_____Birth Date_____

Physical Address:_____ _____ _____ _____ ____
(STREET) *(CITY)* *(STATE)* *(ZIP)*

Mailing Address: _____ _____ _____ _____
(STREET) *(CITY)* *(STATE)* *(ZIP)*

Home Phone (____)_____-_____ **Cell** (____)_____-_____ **Work**(____)____-_____

E-Mail Address: _____

Emergency Contact _____
Name Telephone # Cell#

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.

Any account that is past 30 days is considered past due.
Owner☐ Leasee ☐ 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

Patient Information:

Horses Name	Breed	Sex	Color	Birth year	Discipline

Ranch, Farm, Stable Telephone# Location of Horse Telephone#

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_____

_____EXP .DATE_____ 3 Digit Code_____
Credit Card Number

_____
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