CLIENT INFORMATION FORM

Completion of this information in its entirety required at time of service

OWNER INFORMATION					
Legal Owner Name	Last		First		Middle
Physical Address	Street address		City	State	Zip
Mailing Address	Street address		City	State	Zip
Home Phone # ( )		Cell Phone ( )		Work Phone ( )	
E-mail address				Birth Date	
Social Security	- -	Driver's License	Number	State	Exp.Date

*** PLEASE NOTE THAT ALL INVOICES, RECEIPTS AND STATEMENTS ARE SENT VIA E-MAIL ***

If you prefer to receive communications by paper mail, please indicate here: ☐ I wish to receive paper statements

LEGAL SPOUSE / PARTNER or LEASEE INFORMATION					
Name	Last		First		Middle
Physical Address	Street address		City	State	Zip
Mailing Address	Street address		City	State	Zip
Home Phone # ( )		Cell Phone ( )		Work Phone ( )	
E-mail address				Birth Date	
Social Security	- -	Driver's License	Number	State	Exp.Date

EMERGENCY CONTACT			
Name			
Home Phone # ( )		Cell Phone ( )	

PAYMENT FOR SERVICES IS DUE AT TIME OF SERVICE

If payment is not made at the time of service, outstanding balances after 30 days from time of service will be subject to a 2% finance charge per month. Any account that is past 30 days is considered past due.

Owner ☐ Partner ☐ Leasee ☐ is responsible for payment of all services rendered to the horse(s) by Rogue Equine Hospital. This includes any service requester by the trainer/agent, or authorized caretaker.

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

Name	Signature	Date

Continued on back ----->

CREDIT CARD ON FILE - AUTHORIZATION		
Rogue Equine Hospital accepts most major credit cards and debit cards. All personal information is kept private. You may cancel this authorization at any time by contacting us. The authorization will remain in effect until canceled.		
Card Type:		
Cardholder name (as it appears on card):		
Card Number:	**Expiration Date:**	**Security code:**
Billing Address for Card: Street address City State		Zip Code

I ____ **authorize Rogue Equine Hospital to process the above credit card as "Signature on File" for veterinary services.** I understand that this information will be saved on file for future transactions on my account.

Initial :

______ **Credit cards on file will be run within 48 hours of the invoice date.**

Signature of authorized card holder: _____________________________________ Date: _________________________

PATIENT INFORMATION				
Horse Name				
Registered Name				
Breed:		Sex:	Color:	Age:
Horse Location	☐ At owner's home address		☐ Other location (farm, ranch, stable)	
If stabled at other location, please provide all applicable information:		Location Name:		
		Location Address:		
		Trainer/ Manager/ Property Owner: Contact Number:		