Eye Care® FOR ANIMALS
Seeing life through your pet's eyes

Equine Client Information Form

Owner or owner's representative to complete:

Owner: _____ Email Address: _____

Phone: (home)_____ Phone (cell) _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Handler/Trainer: _____ Phone: _____

Hores'e Name: _____ STALLION • GELDING • MARE

Breed: _____ Color: _____ Age/DOB: _____

Problems/Symptoms/Current Medications: _____

_____

Insurance Company: _____ Policy Number: _____

Referring DVM: _____ Hospital:_____

Office Phone: _____ Fax: _____

Regular DVM: _____ Hospital: _____
(If different from referring DVM)

Office Phone: _____ Fax: _____

REQUIRED CREDIT CARD INFORMATION **required to confirm appointment**

Credit Card: _____ Exp. Date: _____

Name as in appears on card: _____ Billing Address Zip Code: _____

I authorize and direct the veterinarians at *Eye Care for Animals* to diagnose, prescribe, perform minor therapeutic procedures, that their judgement may dictate to be advisable for the patient's well being. No warranty or guarantee has been made as to the results or cure. I also authorize communication with the insurance company listed above as needed.

ALL FEES ARE REQUIRED TO BE PAID IN FULL UPON COMPLETION OF THE VISIT.

In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all cost included in unpaid balance, including a reasoanble collection and/or attorney's fees.

Signature of Responsible Party _____ Date _____

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To be completed by ECFA:

Date/Time of Initial Call:_____ CCR: _____ Caller: rDVM Handler/Trainer Owner

Appointment Date/Time:_____ Equine Facility Location: _____

Facility Contacted: Yes No Name of Contact:_____ Date/Time of Contact:_____ Initials:_____

EQ Client Contacted to Confirm: Yes No Name of Contact:_____ Date/Time:_____ Initials:_____