Columbia Equine Hospital
27841 SE Orient Drive
Gresham OR 97080

New Client Information

CLIENT INFORMATION			
Last Name:	First Name:		
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:	
Email:	Employer:		
Authorized Agent:	Position:	Phone:	
Driver License#	DL State:	Date of Birth:	

PATIENT INFORMATION				
Registered Name:		Barn Name:		
Age:	Breed:	Sex:	Color/Markings:	
Insurance Company:			Surgical?	Mortality?
Policy Number:		Phone Number:		
Referring DVM:				

PAYMENT INFORMATION	
Please call the front office to arrange payment terms	
WE DO NOT BILL INSURANCE COMPANIES -	

I, _____, verify that I am the owner (or owner's authorized agent) of the animal described above, that I have confirmed the accuracy of the information above, and that I hereby give my permission for the necessary procedure(s) to be performed. I understand that payment is required at the time of service and agree to pay all charges and fees in accordance with these terms. I agree that I will not hold Columbia Equine Hospital or any of its employees responsible in case of injury and/or death related to any authorized procedures.

- Signature: _____ Date: _____