# Serenity Equine

2954 Evington Rd. Evington, VA 24550 (434) 525-2244 & 24hr Emergency (434) 845-9577

## New Client Information Sheet

### Owner Information:

Name:_____Address:_____

City:_____State:_____Zip:_____Home phone:_____

Business phone:_____Cell_____Email:_____

**Animal Information:**

Registered Name:_____Nickname:_____

Breed:_____Age:_____Sex:_____Color:_____Tatoo:_____

Presently stabled at:_____Formerly stabled at:_____

Previous Veterinarian:_____

Is this horse insured?_____Company/Agent:_____

Allergies or prior history veterinarian should know:_____

_____

Current trainer or authorized agent for horse:_____

In case of emergency please notify:_____

The above person has my consent for authorization of treatment should I be unavailable in event of an emergency:
_____ (Owner signature)

### Credit Information:

Birth date:_____Driver's License #:_____State:_____

Social Security #:_____Employer:_____

Employer address:_____Telephone:_____

Bank Reference:_____City:_____State:_____

Name of Spouse:_____Spouse's employer:_____

**Payment is expected in full upon receipt of services. Billing privileges must complete and sign below:**

MasterCard #:_____ Exp Date:_____

Visa #:_____Exp Date_____

**I hereby agree that in the event this account does not receive payment for more than 60 days the balance will be forwarded to one of my major credit cards for payment in full.**
I further agree that in the event of default in payment of any amount due, this account should be placed in the hands of any agency or attorney for collection or legal action, to pay for any additional charges incurred due to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

Owner's signature_____Date:_____

# Serenity Equine

2954 Evington Rd., Evington, VA 24550 (434) 525-2244

# History Report

Date: _____ Owner: _____ Telephone: _____

Owner address: _____

Animal name: _____ Age: _____ Breed: _____

Sex: _____ Registration number: _____ Owned how long? _____

**Preventative Medical Program:**

| Immunizations | Date | Other Tests | Date |
|---|---|---|---|
| Rhinopneumonitis | | Coggins Test | |
| Influenza | | Fecal Examination | |
| Tetanus | | Ivermectin | |
| E & W Encephalomyelitis | | Pyrantel Pamoate | |
| Potomac Horse Fever | | Other dewormers | |
| Strangles | | | |
| West Nile Virus | | | |
| Rabies | | | |

Stabled with other horses? _____ New horses in stable? _____
Other horses with similar symptoms? _____ Recent travel? _____

**General Health:**

Attitude: _____ Appetite: _____
Exercise: _____ Diarrhea: _____
Ocular or Nasal Discharge: _____ Pruritus: _____
Sneezing: _____ Incoordination: _____
Coughing: _____ Estrus: _____
Allergies: _____

**Other conditions:**
Laminitis: _____ Colic: _____

**Farrier History:** _____

_____

# SERENITY EQUINE

2954 Evington Rd.
Evington, VA 24550

**Owner**_____ **Horse**_____

## HISTORY

# SERENITY EQUINE

Andrea E. Floyd, DVM
Equine Medicine

2954 Evington Road
Evington, VA 24550

Answering Service
Twenty-Four Hours

Date:

## AUTHORIZATION FOR SURGEON TO OPERATE

This is to certify that the surgical procedure known as _____

_____,
(Name of Operation)

the reason why it is necessary, its advantages and possible complications, as well as possible

alternative modes of treatment have been explained to me by _____
(Name of Veterinarian)

in light of that information the undersigned authorizes _____
(Name of Surgeon or Surgeons)

to perform, under any anesthetic or sedation deemed advisable, the operation stated above and also to perform such additional procedures as may be held to be therapeutically necessary on the basis of findings in the course of the operation.

I understand that complications can occur in spite of the best medical/surgical care. _____
(Owner/Agent Initial)

I have been informed of and have discussed with the clinician, the risks and potential complications associated with the proposed diagnostic and treatment procedure(s). All of my questions have been answered to my satisfaction.

I have been informed of and have discussed with the clinician, the alternatives available to the proposed diagnostic and treatment procedure(s). All of my questions have been answered to my satisfaction.

I have been informed that anesthesia or sedation may be administered for diagnostic and/or treatment procedure(s). I understand the risk of injury or death associated with anesthesia induction, positioning and recovery. Risk is greatest with medically compromised patients.

If an emergency arises and I cannot be contacted to provide authorization for treatment, the attending clinician should act in his or her best judgment ____. OR should not provide additional emergency treatment ____. I agree to pay the additional expenses incurred for the emergency treatment.

The above operation will be performed on:

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Name | Breed | Age | Color |

Any tissues surgically removed may be disposed of by the surgeon(s) or the hospital in accordance with their accustomed practice.

Owner/Agent: _____ Clinician: _____

## ITEMS BROUGHT WITH HORSE
## We recommend the following:

Halter, lead rope, set of brushes, 2 slinkies, 1 winter blanket, 5 Bales of hay, 1 bag Feed, 2 sets of No-bows with 2 sets 5" nylon wraps.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

## CURRENT MEDICATIONS BEING GIVEN BY OWNER

**List the medications, strengths and frequency**

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

# NEW CLIENT NUTRITION INFORMATION

WHAT SUPPLEMENTS, GRAIN AND HAY AND FREQUENCY OF CURRENT FEEDING PATTERN. PLEASE LIST BELOW.

1.

2.

3.

4.

5.

6.

7.

8.