

CANYON EQUINE MEDICAL CENTER

Canyon Large Animal Clinic since 1986

CLIENT INFORMATION

Name: _____ Email _____

Address: _____

Telephone: Cell _____ Home _____ Work _____

CC# _____ X date: _____ Code: _____

PATIENT INFORMATION

Name/Address of Stable: _____

1. Horse Name: _____ Age _____ Breed _____

Color _____ Sex _____ Other _____

Special Information ie vaccine reactions, etc _____

Previous Major Medical or Surgical Care: _____

2. Horse Name: _____ Age _____ Breed _____

Color _____ Sex _____ Other _____

Special Information ie vaccine reactions, etc _____

Previous Major Medical or Surgical Care: _____

I hereby understand that payment is required at the time of service rendered by Canyon Equine Medical Center/Canyon Large Animal Clinic (Dr. Katie Prince DVM) unless other arrangements are made prior to the visit. Failure to keep my account current will result in finance charges, late fees and accounts turned over to collection agencies. I understand that a \$35.00 fee will be charge for any NSF check.

Signature: _____ Date: _____

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