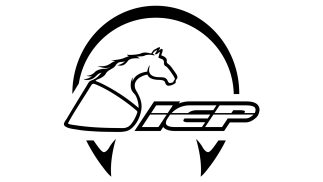
**Innovative Equine Podiatry**

**and Veterinary Services, PLLC**

Sammy L. Pittman, DVM · (903) 718 - 0056

500 Rice Road Collinsville, TX 76233

NEW CLIENT INFORMATION SHEET

**CLIENT INFORMATION** Date:\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trainer/Agent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stable/Barn:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Farrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

1) Full/Registered Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Color:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:\_\_\_\_\_\_\_\_\_\_\_\_

Age/DOB:\_\_\_\_\_\_\_\_Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Patient Insured?\_\_\_\_\_\_\_\_If Yes, Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical Insurance?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mortality?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Full/Registered Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Color:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:\_\_\_\_\_\_\_\_\_\_\_\_

Age/DOB:\_\_\_\_\_\_\_\_Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Patient Insured?\_\_\_\_\_\_\_\_If Yes, Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical Insurance?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mortality?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment**

I am the owner of the above named animal or am responsible for it and have the authority to execute this consent. I hereby authorize the use of anesthetics and/or sedatives as you (Innovative Equine Podiatry and Veterinary Services, PLLC and/or Sammy Pittman, DVM) deem advisable and performances of such surgical or therapeutic procedures as determine necessary. I understand that sedation and/or general anesthesia represents an inherent risk. I agree to indemnify and hold you (Innovative Equine Podiatry and Veterinary Services, PLLC and/or Sammy Pittman, DVM) harmless form and against any and all liability arising out of the performance of any of the procedures.

If I am not the owner, I affirmatively represent and warrant to Innovative Equine Podiatry and Veterinary Services, PLLC that I am the Authorized Agent of the owner and that I possess complete power and authorization and am fully authorized by the owner to seek medical treatment for the horse(s) described above and to complete this form on the owner’s behalf, in the owner’s place and stead.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Signature of Owner or Authorized Agent

**Payment**

I acknowledge that I am fully responsible for payments on any and all professional fees and expenses incurred in connection with the treatments by Innovative Equine Podiatry and Veterinary Services, PLLC. Payments in full are required when services are rendered. Any unpaid balance will be charged to the credit card on file, if provided. Additionally, the client will be responsible for the reasonable cost of collection of any such unpaid amounts, including collection and attorney's fees. Nonsufficient funds fee will be $45 dollars for returned checks and interest on unpaid invoices will accrue at 2% percent monthly, equivalent to a 24% APR.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Signature of Owner or Authorized Agent

I herby authorize Innovative Equine Podiatry and Veterinary Services, PLLC to charge my credit card:

Credit Card #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date:\_\_\_\_\_\_\_\_\_\_CVV Code:\_\_\_\_\_\_\_\_

Name as appears on credit card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type:\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Signature of Owner