90 W LARAMIE DRIVE • RENO NV 89521
(775) 849-0120 • (775) 392-3334 • (775) 849-3129*fax*
www.comstockequine.com

CLIENT INFORMATION

OWNER'S INFORMATION	MR. MRS. MISS. DR.			
	FIRST	MIDDLE	LAST	PHONE
	DRIVER'S LICENSE #	STATE	EXP DATE	ALT PHONE
EMAIL				**OKAY TO CONTACT YOU VIA EMAIL:** **YES NO** *(PLEASE CIRCLE ONE)*
MAILING ADDRESS	STREET	CITY	STATE	ZIP
PHYSICAL ADDRESS	STREET	CITY	STATE	ZIP
				CONSENT TO TREAT: **YES / NO** *(PLEASE CIRCLE ONE)*
ADDITIONAL NAMES ON ACCOUNT / RELATIONSHIP -AND/OR- BARN/STABLE NAME			PHONE	

PATIENT INFORMATION

NAME	SPECIES	BREED	AGE	SEX	COLOR	ADDTL INFO (Allergies, drug reactions, etc.)

PATIENT LOCATION (If different from above address): ____

The undersigned, being the owner of the animal(s) or owner's authorized agent, having been fully informed of the nature and extent of the proposed treatment and/or surgery on the animal(s) and of the hazards and possible consequences involved in such treatment and/or surgery, herby consents to such treatment and/or surgery and agrees to hold Comstock Equine Hospital and its stockholders, professional veterinarians, employees and agents free and harmless from any and all claims, demands, or suits for damages resulting from death of, injury to, pain or suffering of the animal(s) and consequential effects to the undersigned arising out of or resulting from such treatment and/or surgery.

The undersigned further agrees to pay to Comstock Equine Hospital all charges for such treatment and/or surgery, including the costs of all medicine and supplies used or furnished in connection with such treatment and/or surgery, which charges shall be due and payable upon completion of such services and receipt of our statement for services rendered. If payment in full of our statement for services rendered is not received with in thirty (30) days of the date of said statement, the undersigned further agrees to pay interest at the rate of one and one-half percent (1.5%) per month, compounded monthly, on the outstanding balance of said statement from the date of our initial statement until our statement is paid in full together with billing charges of Two Dollars ($2.00) for each additional statement sent to the undersigned.

*I have been notified and informed that a licensed veterinarian is **not** on the premises at all times and that at times my animal(s) may be left unattended.*

Dated this ______ day of ___________________, 20_____.

____
Signature of Owner or Agent

DUE TO RISING OPERATIONAL COSTS, WE HAVE ESTABLISHED THE FOLLOWING POLICY
PAYMENT AT TIME OF SERVICES RENDERED
MASTERCARD VISA CARECREDIT IN-STATE PERSONAL CHECKS

REFERRED BY ____