# EQUINE
# CLIENT/PATIENT INFORMATION

MISSISSIPPI STATE UNIVERSITY
COLLEGE OF VETERINARY MEDICINE

DATE: _____

**Owner Name:**_____ Spouse:_____
(Legal name) **(Last)** **(First)**

Social Security# _____ Email _____ D.O.B_____

Employer _____ Employer Phone# _____

Trainer/Hauler **(if applicable)** _____
(legal name) **(Last)** **(First)**

Have you ever been a client here at the Animal Health Center? Yes No

Full Address (include both your P.O. Box and physical address) _____
_____
_____

Home Phone # _____
Work Phone # _____
Cell Phone # _____
Other # _____

MSU: **student** **employee**

CVM: **student** **employee**

MSU # _____

Regular/Referring Veterinarian (Please complete all information you know):

Name _____
Clinic _____
Address _____ Phone No._____

Patient Name _____

Species _____

Breed _____ Crossbreed: **Yes** **No**

Date of Birth _____ Color _____

Sex _____ Status: Mare Gelding Stallion

Reason for Visit _____

**Owner's Signature**: _____

Date _____

Client Name _____
Last First

Address _____

Patient Name _____

I, the undersigned owner or authorized agent of the patient identified above, am responsible for the same and have authority to execute this consent to perform diagnostic studies and therapies. I understand that some risks always exist for anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks with my attending veterinarian before the procedure is initiated. Should unexpected life-saving emergency care be required, the Hospital's staff has my permission to provide such treatment and I agree to pay for such care.

I understand Mississippi State University Animal Health Center is a teaching facility for veterinary medical students. I authorize the Animal Health Center to use medical information to include images and photographs of the above-named animal(s) for educational purposes.

I understand an estimate of the costs for veterinary services is hereby provided to me and that I am encouraged to **discuss all fees attendant to such care before services are rendered** and during my pet's admission. I agree to assume financial responsibility for the balance of **ALL** services rendered on a cash, credit card or check basis at the time my pet is discharged from the hospital. In the event that my pet is hospitalized for more than 48 hours and my attending doctor does not or is unable to contact me, I understand it is my responsibility to call the attending doctor to inquire as to the medical status of my pet and fees incurred for medical services up to that day.

I further agree that I, or an authorized agent of mine, will pick up and pay for all accrued charges on my animal within 5 days after receiving written or oral notification at the above address that he/she is ready to be released from the hospital.

_____
Signature of Owner/Agent

_____
Date

**FEE ESTIMATES ARE NOT FEE QUOTATIONS OR GUARANTEES, BUT ATTEMPTS TO INFORM THE OWNER OF ANTICIPATED EXPENSES.**

Attending DVM _____

Student _____ _____
Signature of Owner/Agent