Coastal Equine
VETERINARY SERVICE
P.O. Box 15370 Chesapeake, VA 23328
(757) 421-3900

Client Information Form

Thank you for choosing Coastal Equine Veterinarian Services. Please fill out the following form to ensure we provide the best care for your horse(s). If you have any questions, feel free to ask our staff.

Client Information

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Alternate Phone: _____

Email: _____

Emergency Contact Information: Name: _____

Relationship: _____ Phone Number: _____

Horse Information (For multiple horses, please attach additional pages.)

Horse Name: _____ Show/Reg. Name: _____

Breed: _____ DOB: _____ Color: _____ Gender: ☐ Mare ☐ Gelding ☐ Stallion

Current Veterinarian (if any): _____

Microchip Number (if applicable): _____

Barn name and address:_____

Medical History (new clients only):

Does your horse have any known medical conditions or allergies? ☐ Yes ☐ No (If yes, please specify)

Is your horse on any current medications or supplements? ☐ Yes ☐ No (If yes, please list)

Date of Last Vaccinations: _____ Date of Last Deworming: _____

Insurance Information (if applicable) Is your horse insured? ☐ Yes ☐ No

Insurance Provider: _____

Care & Billing Authorization: I authorize Coastal Equine Veterinarian Services to provide medical treatment to my horse(s). I understand that payment is due at the time of service unless prior arrangements have been made. I agree to be responsible for all charges incurred.

Signature: _____ Date: _____ Please return this completed form via email prior to your first appointment. We look forward to caring for your horse!