503-631-4100
NEW PATIENT FORM

Date:_____

Registered Name: _____ Horse's Barn Name: _____

Breed: _____ Color & Markings: _____

Age: _____ Sex: _____ Weight: _____ Height : _____

Intended Use:_____

PREVENTIVE MEDICINE HISTORY

Please note month & year when last administered or performed

Vaccinations: Flu (intranasal)_____ Rhino _____ Flu/ Rhino (IM) _____ EWT_____ PHF_____

Rabies _____ Strep Equi (strangles)_____ WNV_____

Last FEC and Parasite control: _____

Last Coggins Test:_____ Last CBC & Profile blood work: _____

Dental Care Received _____

MEDICAL HISTORY

Allergies: (vaccine, drug, feed, etc):

Past Medical Problems and/or Surgeries:

Current Medications or Therapy:

Special Instructions:

Farrier name, phone # and any corrective shoeing:

INSURANCE INFORMATION

Company_____ Type of Coverage _____

Contact _____ Policy Number _____

Address _____

Phone _____ Fax _____

BARN INFORMATION

Barn/Stable _____ Barn Phone # _____

Barn Owner/Manager _____ Trainer Name & Phone #_____

Horse Owner: _____ Owner's Phone # _____