



Prises Creek Veterinary Service
6799 US 40 East
Lewisburg, Ohio 45338
(937)962-7035

Thank you for choosing Prises Creek Veterinary Service to care for your horse. In order to best serve you please complete the following:

Tell us about you!

Your Name: _____ Spouse: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment/Ocupation: _____

E-Mail Address: _____ Is the horse located at address above? Yes No

If no please provide barn name: _____

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

Would you like a written estimate of cost prior to the treatment of your horse? Yes No?

If any other person is authorized to make medical decisions for your horse besides listed above please list here:

Name: _____ Title: _____

How did you hear about us? (please circle): Website? Sign/Drive By?

Newspaper? Referral? Who may we thank: _____

Other: _____

ALL FEES ARE DUE AT THE TIME OF SERVICE:

I authorize the treatment of my horse by all staff at Prises Creek Veterinary Service and confirm that I am older than 18 years of age. I will assume responsibility for all charges incurred in the care of all animals listed under my name and that all payment is expected at the time of service.

Client Signature: _____ Print: _____ Date: _____

Photo agreement (OPTIONAL):

I authorize photographs to be taken of all of the animals listed under my name including myself for educational and/or promotional use that include but are not limited to the clinic website, Facebook, or printed educational/promotional materials.

Client Signature: _____ Print: _____ Date: _____

Tell us about your Horse!

Name: _____ Breed: _____

Gender/Status (please circle): Female Spayed Female Male Neutered Male

Birth Date/Approx. Age _____ Color and Markings: _____

Where was your pet obtained from (please circle): Shelter/Rescue Pet Store Family/Friend
Breeder Other: _____

Health Concerns and Medical History

Where can we obtain your horse's previous medical history (name and phone number)? _____ Date of last exam: _____

Known health issues or chronic ailments: _____

Any known allergies/Vaccine Reactions: _____

Current Medications taken: (please include prescriptions, supplements or over the counter): _____

Vaccine History

Date of vaccinations and what was given:

What are your goals for today's visit? _____

Please circle areas of concern and explain below:

