



Rogue Valley Equine Hospital

14099 Hwy 62
Eagle Point, OR 97524
Phone (541)826-9001 Fax (541)826-1099
www.roguevalleyequine.com

William W. Ferguson, D.V.M.
Thomas R. Timmons, D.V.M.
Mitchell K. Benson, D.V.M.

HOSPITAL ADMISSION FORM

All clients are required to provide complete information prior to admission. Our purpose is to implement our medical protocol at the earliest indication of need. We must have your information and authorization to proceed.

CLIENT INFORMATION

Owner's name: _____ Date of Birth: _____

Social Security #: _____ - _____ - _____ Driver's License # _____ Exp _____

Physical Address _____

Mailing Address _____

Home: (_____) _____ Work: (_____) _____

Cell: (_____) _____ Emergency: (_____) _____

Employed By: _____

Employer's Address: _____

Name of any other person authorized to receive information regarding the treatment of the patient named below: _____

Referring Veterinarian: _____

Surgical Insurance _____ yes _____ no _____ Mortality Insurance _____ yes _____ no _____

Insurance Company _____

Phone # _____ Policy number # _____

PATIENT INFORMATION

Animal's Name: _____ Age: _____

Sex: _____ Species: _____ Breed: _____ Color: _____

Markings: _____ Brand: _____ Tattoo: _____

Current Diet: _____

Hay: Type _____ How Much _____ When: _____

Grain: Type _____ How Much _____ When: _____

Feed Additives (please specify) _____

HOSPITAL POLICY

Visiting Hours: **BY APPOINTMENT ONLY**

Monday thru Friday 10:00 am to 3:00 pm

Saturday & Sunday By Appointment Only

Discharge hours: **3:30 pm to 4:30 pm only.**

A deposit equal to the estimated treatment fee is required on admission, with any remaining balance due at the time of discharge.

Professional fees and costs estimated are approximate. I as owner and or authorized agent will be responsible for any and all charges incurred to insure the well being of the above named animal. I further agree to pay for all services performed on the above mentioned horse pursuant to these provisions. Any remaining balances will be subject to a 2% finance charge incurred monthly.

I hereby authorize Rogue Valley Equine Hospital to charge the below account for services rendered and also agree to pay for any and all collection fees and / or legal fees incurred on the below account.

Visa/Mastercard: _____ Exp. Date _____

Card holder name: _____

Card holder signature: _____

Fee estimate: \$ _____ Deposit: \$ _____

(Owner/Agent) Signature: _____ Date _____

Admitting Doctor: _____

CONSENT

Animal's name _____

I am the owner, or responsible party of the above named animal, and have the authority to execute this consent. I am aware of inherent risks involved with any anesthetic or surgical procedure, and post operative recovery. I hereby authorize Rogue Valley Equine Hospital to perform the following procedures:

I, hereby also authorize the use of such anesthetics as you deem advisable and any surgical or therapeutic procedures implemented. I understand unforeseen conditions may arise in the course of the operation, requiring swift action.

I, hereby authorize any procedure in addition to or different from those now contemplated, including euthanasia (humane destruction), to avoid cruel and unnecessary suffering by the animal. I further request and authorize Rogue Valley Equine Hospital and staff members to do whatever Rogue Valley Equine Hospital and staff members deem advisable.

I, hereby acknowledge that there is not an attendant, technician, or doctor at the above referenced facility 24 hours a day.

I, agree to indemnify and hold Rogue Valley Equine Hospital and all staff members harmless from and against any and all liability arising out of the performance of any of the procedures referenced above.

Owner's Signature _____ Date: _____