



## OWNER INFORMATION

OWNER NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PH: \_\_\_\_\_ CELL PH: \_\_\_\_\_ WORK PH: \_\_\_\_\_ FAX#: \_\_\_\_\_

SS# \_\_\_\_\_ EMAIL: \_\_\_\_\_ DL #: \_\_\_\_\_ STATE: \_\_\_\_\_

SPOUSE/PARTNER NAME: \_\_\_\_\_ CELL PH: \_\_\_\_\_ WORK PH: \_\_\_\_\_

### PRIMARY CONTACT PERSON FOR HORSE IF NOT OWNER:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PH: \_\_\_\_\_ CELL PH: \_\_\_\_\_ WORK PH: \_\_\_\_\_ FAX #: \_\_\_\_\_

**ARE THERE ADDITIONAL OWNERS/PARTNERS FOR THIS HORSE? YES NO**

IF YES PLEASE FILL OUT ADDITIONAL OWNER INFORMATION SHEET

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## HORSE INFORMATION

REGISTERED NAME: \_\_\_\_\_ NICKNAME: \_\_\_\_\_

BREED: \_\_\_\_\_ COLOR: \_\_\_\_\_ SEX: Mare Gelding Stallion AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

REFERRING VETERINARIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

TRAINER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

FARM: \_\_\_\_\_ FARM MNGR: \_\_\_\_\_ PHONE: \_\_\_\_\_

AUTHORIZED AGENT: \_\_\_\_\_

I authorize my agent to make medical, procedural, and surgical decisions pertaining to my horse in my absence. **YES NO**

**DOES THE HORSE HAVE INSURANCE: YES NO**

I understand that if the horse admitted to SLREH is covered by insurance, it is necessary for the owner to contact the agent or adjuster of that insurance company for the purpose of notifying them of any anticipated procedures, which may affect that coverage, and I further agree that I shall make such contact. I understand that payment in full to SLREH is required at the completion of services. The insurance carried for animals is handled differently than the medical insurance carried for yourself. We are not generally reimbursed directly by the insurance companies for services rendered. San Luis Rey Equine Hospital will be happy to assist in completing the required insurance paperwork for your reimbursement once the account has been paid in full.

POLICY #: \_\_\_\_\_ INSURANCE CARRIER: \_\_\_\_\_

AGENT/ADJUSTOR NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_