South Shore Equine Clinic & Diagnostic Center
151 Palmer Road Plympton, MA 02367
Phone 781-585-2611
Fax 781-585-0611
www.ssequineclinic.com

Dear Client,

South Shore Equine Clinic & Diagnostic Center strives to provide the most up to date, comprehensive and compassionate treatment for equine patients. Our doctors utilize the latest techniques and equipment available to equine veterinarians to ensure that every patient receives the highest quality care. The services include routine farm work, preventative health exams, prepurchase exams, performance/ lameness exams & diagnosis, upper airway evaluation, elective orthopedic and soft tissue surgery, LASER surgery, stem cell injections, Platelet Rich Plasma Injections (PRP), full in-house laboratory; the latest techniques and equipment available to equine veterinarians, including endoscopy, gastroscopy, digital radiography, EKG monitoring, ultrasonography, shockwave therapy, magnetic resonance imaging (MRI), and much more.

As with other medical professionals, we would like to remind you that we expect payment at the time services are rendered. Payment can be made with cash, check or valid credit card. We accept Visa, Mastercard, Discover Card, and American Express. For those clients who cannot be present at the time of service, we ask that you keep your credit card information on file with us or if possible, you may leave a form of payment with your agent or attached to your horse's stall. You may also have charges applied to your credit card after each visit by placing a phone call to the clinic. If we do not hear from you within 48 hours, payment will automatically be applied to your credit card.

We also offer CareCredit, a system that provides short term/no interest financing, or long term low interest financing. For more information, you can visit the CareCredit website at www.carecredit.com or contact our office.

Please help us maintain accurate and complete records by taking a few minutes to fill out the enclosed forms, one with your information, and one about your horse. If you have more than one horse, please be sure to fill out a patient information form for each horse. Our goal is to have all of this information on file before your next scheduled appointment. With that in mind, we ask that you please return these forms by mail or fax as soon as possible. If you have any questions, please feel free to give our office a call.

Our goal is to provide you with the highest quality veterinary medical care for your horses and excellent customer service to you. A clearly established policy and updated medical records will help us accomplish this. Thank you for helping us!

Sincerely,

Mark T. Reilly, DVM, Dipl. ABVP
Linda J. Cimetti, DVM

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REGISTRATION FORM

OWNER'S NAME _____ DATE _____
EMAIL ADDRESS _____

MAILING ADDRESS:
STREET _____
TOWN _____ ZIP CODE_____

HOME ADDRESS: ☐USE MAILLING ADDRESS FROM ABOVE
STREET _____
TOWN _____ STATE ____ ZIP CODE_____

TELEPHONE NUMBERS:
HOME PHONE _____ CELL PHONE _____
WORK PHONE _____ EMPLOYED BY _____
FAX NUMBER _____

HOW DID YOU LEARN OF OUR HOSPITAL?
☐YELLOW PAGES ☐SIGN ☐PUBLICATION _____
(PUBLICATION NAME)
☐BARN _____ ☐INDIVIDUAL_____
(BARN NAME) (IF FROM AN INDIVIDUAL, PLEASE LIST THEM SO WE CAN THANK THEM)
☐WEBSITE ☐OTHER _____
(PLEASE LIST)

PREFERRED METHOD OF PAYMENT:
☐CASH ☐CHECK (MUST BE PAID AT TIME OF EACH APPOINTMENT)
☐CREDIT CARD (VISA, MC, AMEX, DISCOVER) ☐CARECREDIT

CREDIT CARD INFORMATION:
TYPE OF CARD ☐VISA ☐MASTERCARD ☐AMEX ☐DISCOVER ☐CARECREDIT
NAME AS IT APPEARS ON CARD_____
CREDIT CARD ACCOUNT NUMBER _____
EXPIRATION _____ CVV _____
ADDRESS ASSOCIATED WITH CARD ☐USE MAILING ADDRESS FROM ABOVE
STREET _____
TOWN _____ STATE ____ ZIP CODE_____

AUTHORIZATION

A RECORD OF YOUR PAYMENT WILL POST ON YOUR MONTHLY STATEMENT.

YOUR SIGNATURE GIVES APPROVAL FOR DRUGS, X-RAYS, DIAGNOSTICS, EMERGENCY TREATMENTS, ETC., TO BE PERFORMED ON YOUR HORSE IN THE EVENT OF AN EMERGENCY OR IF YOU ARE UNABLE TO BE PRESENT FOR AN APPOINTMENT. I ALSO UNDERSTAND THAT THESE CHARGES WILL BE PAID IN FULL AT THE TIME SERVICES ARE RENDERED AND THAT A DEPOSIT MAY BE REQUIRED FOR SURGICAL/ MEDICAL TREATMENT.

SIGNATURE _____ DATE _____

METHOD OF PAYMENT FOR TODAY: ☐CASH ☐CHECK ☐CREDIT CARD ☐CARECREDIT

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PATIENT INFORMATION FORM

PLEASE FILL OUT ONE FORM FOR EACH HORSE

OWNER'S NAME _____ DATE _____

PATIENT INFORMATION:

HORSE'S NAME: _____ HORSE'S BARN NAME: _____
BREED _____ AGE _____ SEX _____ COLOR _____

DOES YOUR HORSE HAVE A MICROCHIP? ☐YES ☐NO
IF SO, WHICH BRAND?_____ MICROCHIP NUMBER _____

BARN INFORMATION:

BARN NAME:_____ TELEPHONE _____
STREET _____
TOWN _____ STATE ____ ZIP CODE _____
BARN MANAGER/CONTACT _____ TRAINER_____

IS YOUR HORSE INSURED? ☐YES ☐NO (But I intend to get mortality and major medical insurance)
TYPE OF INSURANCE: ☐MORTALITY ☐SURGICAL ☐MAJOR MEDICAL ☐LOSS OF USE
INSURANCE COMPANY NAME _____
TELEPHONE _____ FAX _____

MEDICAL HISTORY:

DOES YOUR HORSE HAVE ANY KNOWN ALLERGIES? (MEDICATIONS, FOODS, ETC) ☐YES ☐NO
IF SO, PLEASE LIST _____
_____

IS YOUR HORSE UP TO DATE ON THE FOLLOWING VACCINATIONS?
(PLEASE CHECK ALL THAT APPLY AND LIST THE DATE OF VACCINATION)

☐RABIES _____ ☐EEE/WEE_____ ☐TETANUS_____
☐RHINO_____ ☐INFLUENZA_____ ☐WEST NILE_____
☐STRANGLES_____ ☐PHF_____ ☐OTHER_____

DEWORMING SCHEDULE: ☐DAILY ☐ROTATION

IS THIS HORSE CURRENTLY ENROLLED IN THE PREVENTICARE PROGRAM? ☐YES ☐NO

OTHER PERTINENT MEDICAL HISTORY _____
_____
_____
_____

PREVIOUS VETERINARIAN(S) THAT TREATED THIS HORSE_____
_____

AUTHORIZATION

I HEREBY AUTHORIZE THE VETERINARIAN TO EXAMINE, PRESCRIBE FOR, OR TREAT THE ABOVE DESCRIBED HORSE. I ASSUME RESPONCIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF THIS ANIMAL. I ALSO UNDERSTAND THAT THESE CHARGES WILL BE PAID IN FULL AT THE TIME SERVICES ARE RENDERED AND THAT A DEPOSIT MAY BE REQUIRED FOR SURGICAL/MEDICAL TREATMENT.

SIGNATURE _____ DATE _____