



# Coast Equine

Veterinary Services

Cori Phinn, DVM

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831.707.4050

## Client Registration and Emergency Authorization Form

Thank you for choosing Coast Equine. I am dedicated to providing your horse with high quality compassionate medicine. I look forward to becoming an important part of keeping your horses happy and healthy.

Owner's Name: \_\_\_\_\_

Spouse: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone number: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Email: \_\_\_\_\_ Stable: \_\_\_\_\_

Horse's Registered Name: \_\_\_\_\_

Barn Name: \_\_\_\_\_ Breed: \_\_\_\_\_

Year of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Color: \_\_\_\_\_

Insured  Y  N Contact Number for Insurance \_\_\_\_\_

Max. amount of money approved in emergency \_\_\_\_\_

Horse's Registered Name: \_\_\_\_\_

Barn Name: \_\_\_\_\_ Breed: \_\_\_\_\_

Year of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Color: \_\_\_\_\_

Insured  Y  N Contact Number for Insurance \_\_\_\_\_

Max. amount of money approved in emergency \_\_\_\_\_

In the case of a medical emergency, if I cannot be reached, I hereby give the below person(s) permission to authorize Coast Equine to provide any medical treatment deemed necessary for my horses. I will be responsible for charges incurred in that treatment.

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Owners signature: \_\_\_\_\_ Date: \_\_\_\_\_