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PRINT FORM

BYRON V. REID, VMD,PA dba REID & ASSOCIATES EQUINE CLINIC
EQUINE HYPERBARIC CENTER OF SOUTH FLORIDA

1630 F Road, Loxahatchee, FL 33470
Office: 561-790-2226 Fax: 561-798-1310

Date:

Time:

Owner: Address: City: State: Zip: Home: Work: Cell: Barn: Email:

Farm/Trainer: Address: City: State: Zip: Home: Work: Cell: Barn: Email:

Name in case of emergency and you cannot be reached? Phone:

Insurance Co: Agent: Phone:

Referring Vet: Phone: Email:

Patient: Age: Sex: Breed:
(REGISTERED NAME)

Color/markings: Tattoo/ Brand: Stable Vices:

(Quarter Horse/Paint) Are you aware of any "Impressive" bloodlines in his/her ancestry? Yes ☐ No

If yes, has he/she been tested? Yes ☐ No Results: Coggins: Last Tetanus:

Description of present illness:

How long present: Any known allergies?

Please put type of feed, quantity & frequency of feeding:

Grain: Hay:

Is horse pregnant? Foundered? Previous history of colic?

Any history we need to know:

List medications your horse is on or received recently:

Hyperbaric horses only: Any evidence of guttural pouch or sinus infection?

**** FLORIDA LAW: 72 HOUR WITHDRAWAL FROM RACE DAY OF HYPERBARIC OXYGEN ****

CLEAR FORM

I, the undersigned owner (or authorized agent for the owner), of the above mentioned patient, authorize Reid & Associates and/or Equine Hyperbaric Center of South Florida to administer any necessary treatment and perform any necessary surgical, diagnostic,hyperbaric and therapeutic procedures on the basis of findings during the course of evaluation. I, also consent to the use of anesthetics to include but not limited to General Anesthesia and have been advised to the nature of the procedures/operations and accept the risks thereof. I understand that hospital / hyperbaric support personnel will be employed as deemed necessary by the veterinarians. I realize that results cannot be guaranteed. If I elect humane destruction or the above mentioned animal dies, I give permission to Reid & Associates personnel to dispose of said animal as they see fit.

Furthermore, I assume all financial responsibilities for all charges incurred by the patient and understand that a deposit of $_____is due on admission and that any amount over the deposit amount will be due every 24 hours thereafter, and updated charges will be placed on the credit card and/or a check will be due. I understand that I may pay with cash, check, Visa, Mastercard, American Express and/or Discover and if I use a check or cash a credit card must be left as backup in the event a check or cash is not available when the next amount is due.. I do hereby authorize Reid & Associates and/or Equine Hyperbaric Center of South Florida to bill my credit card until all fees are paid in full. I understand that in the event it would be necessary to utilize the services of an attorney for collection of my account to Reid & Associates and/or Equine Hyperbaric Center of South Florida, I agree to pay attorney's fees, cost of collection, and a 1 1/2% interest monthly finance charge monthly on any unpaid amount.

Admitted by/witness: _____ Signature Owner/Agent: _____