
Kilshannagh Veterinary Clinic

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Tel. 518. 329.5213 Fax 518.329.0026
www.kvclinic.com

CLIENT REGISTRATION (EQUINE)

Please complete and mail/fax/e-mail to our office. Copy and complete as many of the additional horse information sheet(s) as needed. Thank you.

Client Information:

Name:

SSN#:

Address:

City:

County:

State:

ZIP:

Home Phone:

Business Phone:

Cell:

Best time to call:

E-mail:

Payment Policy: WE REQUIRE A CREDIT CARD ON FILE TO SECURE AN ACCOUNT WITH US. (COMPLETE AND RETURN THE CREDIT CARD AUTHORIZATION FORM BELOW). ANY BALANCE ON YOUR ACCOUNT OVERDUE BY MORE THAN 30DAYS WILL BE AUTOMATICALLY CHARGED TO THIS CREDIT CARD. ANY BALANCE OVERDUE BY 60 DAYS OR MORE WILL BE SUBJECT TO FINANCE CHARGES AT THE PREVAILING RATE INDICATED ON YOUR INVOICES /STATEMENTS AND PLACED IN COLLECTION.YOU WILL BE LIABLE FOR ALL LEGAL FEES INCURRED SHOULD YOUR ACCOUNT BE PLACED IN COLLECTION.

Horse Information:

Show Name:

Barn Name:

Age:

Breed:

Color:

Sex:

Emergency Contact:

Insurance Company/telephone:

Medical History (ongoing conditions only): _____

Barn address (if different from above):

Barn telephone:

Barn Owner/Manager:

ADDITIONAL HORSE INFORMATION

Horse Information:

Show Name:

Barn Name:

Age:

Breed:

Color:

Sex:

Emergency Contact:

Insurance Company/telephone:

Medical History (ongoing conditions only): _____

If applicable:

Barn address (if different from above):

Barn telephone:

Barn Owner/Manager:

Horse Information:

Show Name:

Barn Name:

Age:

Breed:

Color:

Sex:

Emergency Contact:

Insurance Company/telephone:

Medical History (ongoing conditions only): _____

If applicable:

Barn address (if different from above):

Barn telephone:

Barn Owner/Manager:

NEW ACCOUNT HOLDER (EQUINE CLIENTS).
CREDIT CARD SECURITY.

Dear Client,

To secure an account with us, we require that you provide us with a credit card authorization to keep on file as security. Please complete the following information:

Name:

Address:

Credit Card Billing Address (if different from mailing address):

Tel. no:

CREDIT CARD INFORMATION:

Mastercard Visa Discover

Credit Card # _____ Exp Date _____

Cardholder Name _____ 3-digit security code _____

This credit card information will be held in the strictest of privacy. This paper authorization will be destroyed immediately after the data has been stored in a security-encrypted electronic format. **I acknowledge that this authorization will remain in effect unless I cancel the authorization in writing to Kilshannagh Veterinary Clinic P.C.**

I confirm that my signature on this form is in lieu of my credit card imprint/swipe and **authorize Kilshannagh Veterinary Clinic P.C. to charge my credit card any amount due should my account become past due by more than 30 days after the billing cycle ends.**

Cardholder signature _____ Date _____

Please mail or fax this form to the address/fax number above or email to admin@kvclinic.com.