



CHASTAIN

~ equine medicine ~

Alan D. Chastain DVM LLC

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Trainer Name _____ Cell Phone _____

TRAINER OWNER/HORSE INFORMATION SHEET

Owner Name _____

Address _____

City _____ State _____

Zip _____ Phone _____ Fax _____

Email _____ Cell Phone _____

Horse Name _____ % Owned _____

Horse Name _____ % Owned _____

Horse Name _____ % Owned _____

Horse Name _____ % Owned _____

Horse Name _____ % Owned _____

Horse Name _____ % Owned _____

Owner Name _____

Address _____

City _____ State _____

Zip _____ Phone _____ Fax _____

Email _____ Cell Phone _____

Horse Name _____ % Owned _____

Horse Name _____ % Owned _____

Horse Name _____ % Owned _____

Horse Name _____ % Owned _____

Horse Name _____ % Owned _____

Horse Name _____ % Owned _____

1. I am the Owner or Agent of the above named animal(s) and am responsible for it and have the authority to execute this consent.
2. I hereby authorize the use of such anesthetics as you deem advisable and the performance of such surgical and therapeutic procedures as you determine to be indicated and have been informed of the risks inherent in their use.
3. If the patient is insured, I agree that it is my responsibility or the responsibility of the Owner to notify the insurance company as required by the terms of the policy. If the Insurance company should request information from Alan D. Chastain DVM, I authorize you to release that information.
4. I consent to taking of any photographs, moving pictures, images or other visual aids in the course of treatment, for the purpose of treatment and advancing veterinary medical knowledge.

Signature _____ Date _____