



96 Warn Ave  
Pine Bush, NY 12566

PHONE: 845-361-4917

FAX: 845-361-1797

## New Patient Form

Name: \_\_\_\_\_ Account: \_\_\_\_\_

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

\_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name(s) and Location of Horse(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### CREDIT CARD

Discover Amex Mastercard Visa

Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Sec. Code: \_\_\_\_\_

Billing Address (*if different from mailing*): \_\_\_\_\_

\_\_\_\_\_

I understand that the credit card provided above will be kept on file for the purpose of securing an account with Pine Bush Equine Services and Veterinary Hospital. I also understand that this card will be used should my account become past due by more than 30 days after the billing cycle ends.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_