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**B.W. Furlong & Associates**  
*Oldwick, NJ | Wellington, FL*  
**Peak Performance Equine Services**  
*Middleburg, VA | Ocala, FL*

*Peak Performance*  
 LISA L. CASINELLA, DVM  
 JILL A. COPENHAGEN, DVM  
 ALYSON L. BABER, MVB

**Clinic Admission Form**

**For Office Use Only:**

**Appt Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Appt Time:** \_\_\_\_:\_\_\_\_AM/PM/DO **Arrival Time:** \_\_\_\_:\_\_\_\_AM/PM  
**Treating Vet:** \_\_\_\_\_ **Rdvm:** \_\_\_\_\_ **Admitting Tech\*:** \_\_\_\_\_ *\*(after hours/weekend)*  
**Deposit Rcv'd:** YES/NO/NA **Acct #:** \_\_\_\_\_ **Scanned In:** \_\_\_\_\_

**OWNER INFO:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone\*: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
*\*Please circle best # to contact for updates*  
 Email: \_\_\_\_\_  
 Auth'd Agent/Shipper: \_\_\_\_\_  
 Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PATIENT INFO:**

Nickname: \_\_\_\_\_  
 Registered Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Breed: \_\_\_\_\_ Sex: F/St/G  
 Color: \_\_\_\_\_ Discipline: \_\_\_\_\_  
 Is patient insured: YES/NO Allergies: \_\_\_\_\_  
 Feeding Instructions: \_\_\_\_\_  
 \_\_\_\_\_  
 Medications/Supplements: \_\_\_\_\_  
 \_\_\_\_\_

**Consent for Treatment:**

I am the owner or authorized agent for the owner of the above described horse and have the authority to execute this consent. I hereby consent and authorize the performance of the following procedure(s) and/or operations:

**Reason for Admission/Procedure-** \_\_\_\_\_

I certify that I own/have assumed financial responsibility for the above described animal and I do hereby consent and authorize Brendan W. Furlong, M.V.B., Equine Veterinarian, P.A. and its staff to hospitalize this animal and administer vaccinations, medications, tests, surgical procedures, anesthetics or treatments the doctors deem necessary for the health, safety, or well being of the above animal while under their care and supervision. I have been advised as to the nature of the procedure(s) and/or operations and have been informed of the associated risks. I realize that results cannot be guaranteed and that complications may occur despite the best efforts.

If this animal should injure itself, refuse food, become ill or die while in the hospital, I will hold Brendan W. Furlong, M.V.B., Equine Veterinarian, P.A. and its staff free of any/all responsibility and/or liability. I understand that after hours and weekend attendance of hospital patients is at the discretion of the veterinarian and that a veterinarian may not be on the premises in attendance at all times.

**Case Study Consent:**

\_\_\_\_\_ (*please initial*) I consent to the use of the above described animal's case study to be used for medical education and teaching purposes, provided neither the owner nor the patient is identified by name.

**Payment Authorization:**

I further realize that I am responsible for payment of the above procedures and treatments IN FULL AT TIME OF DISCHARGE. In the event I fail to comply with these terms, I authorize Brendan W. Furlong M.V.B., Equine Veterinarian, P.A. to charge the bill in its entirety to the credit card provided (below) including all applied service fees at 2% of balance per each month unpaid.

**Deposit Amount Required:** \$ \_\_\_\_\_

**Visa/MC/Amex/Discover/Care Credit\*\*:** \_\_\_\_\_ **Exp:** \_\_\_\_/\_\_\_\_ **CVV:** \_\_\_\_\_

**\*\*Care Credit not accepted for Furlong's Soundness Center**

*I have read and understand this authorization and consent.*

**Owner/Authorized Agent (PRINTED):** \_\_\_\_\_

**Owner/Authorized Agent (SIGNED):** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_