



Equine Medical  
Associates

**DOCTORS:**  
STEPHANIE L. FRANK, DVM, DACVIM  
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**CONTACT:**  
25200 TRABUCO ROAD  
LAKE FOREST, CA 92630  
P. 949-588-6950  
office@horsevets.com

## New Client Form

Welcome to Equine Medical Associates! Please complete and return the following form. We look forward to working with you and your horse.

E-mail: [office@horsevets.com](mailto:office@horsevets.com)  
 Fax: (916) 652-7662  
 Mail: 25200 Trabuco Rd, Lake Forest, CA 92630

Owner: \_\_\_\_\_

First Middle Last

Spouse: \_\_\_\_\_

First Middle Last

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

Street City State Zip

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

Street City State Zip

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Spouse Phone: \_\_\_\_\_

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

Credit Card: \_\_\_\_\_

Type Number Security Code Expiration

Family Members/Others Authorized To Make Decisions Regarding Care of Horse:

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship



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Horse #1: \_\_\_\_\_  
Barn Name Registered Name (If Different)  
Age/DOB: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Gender: \_\_\_\_\_  
Stable: \_\_\_\_\_ Stall Number: \_\_\_\_\_ Trainer: \_\_\_\_\_

Horse #2: \_\_\_\_\_  
Barn Name Registered Name (If Different)  
Age/DOB: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Gender: \_\_\_\_\_  
Stable: \_\_\_\_\_ Stall Number: \_\_\_\_\_ Trainer: \_\_\_\_\_

Horse #3: \_\_\_\_\_  
Barn Name Registered Name (If Different)  
Age/DOB: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Gender: \_\_\_\_\_  
Stable: \_\_\_\_\_ Stall Number: \_\_\_\_\_ Trainer: \_\_\_\_\_

Horse #4: \_\_\_\_\_  
Barn Name Registered Name (If Different)  
Age/DOB: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Gender: \_\_\_\_\_  
Stable: \_\_\_\_\_ Stall Number: \_\_\_\_\_ Trainer: \_\_\_\_\_