ALL CREATURES VETERINARY HOSPITAL

Thank you for choosing ACVH to care for your pet(s).
Please fill out the following form completely.

Date _____

Last name _____ First name_____

Address _____

City_____ State_____ Zip Code _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Employer _____ Spouse/Other _____

How did you hear about our clinic? _____

Pet Information

Name _____ Species _____ Breed _____ Age or DOB _____

Color _____ Sex_____ Spayed Neutered

The following information is required for your account and will remain strictly confidential.

Social Security # _____ OR D. L. # _____

***PAYMENT IS DUE AT TIME OF SERVICE ***

How will you be paying for today's services?

If balance is not paid at time of service your invoice will be subject to a $300 collections fee added to the invoice balance.

Cash _____ Credit Card _____ Care Credit _____

****We're sorry, we do not accept checks.***

Please read thoroughly before signing

It is our goal to do our very best to meet all of your pet(s) health care needs. In return we ask that our clients accept financial responsibility for all charges incurred in the treatment of their pet and accept that payment is due at the time of service. Please feel free to ask for an estimate at any time during your visit. We also want you to feel free to ask any questions you may have.

Client Agreement and signature: _____