All God's Creatures Holistic Healthcare, LLC

6679 E. State Road 164

Celestine, IN 47521

(812) 536-2276

Client Registration Payment Form

The below form will be kept confidential.

Owner's Last Name: _____ First Name: _____

Address: _____

City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Preferred Method of Contact for automatic reminders (circle one): Voicemail / Text / Email

If text or voicemail selected please provide the preferred phone number: _____

Preferred Method of Contact for staff to contact you (circle one): Home / Cell / Email

Date of Birth: _____

Driver License Number (required if using checks): _____

Employer: _____Work Phone Number: _____

Spouse/Co-Owner's Name: _____ Spouse/Co-Owner's Cell Phone Number: _____

Who told you about us? _____

PAYMENT IS DUE AT TIME OF SERVICES

Method of payments available:

Cash Personal Check Credit Card/Debit Card

Payment is due today for services.

I understand that I am responsible for all charges for the care of my pet(s) provided by All God's Creatures Holistic Healthcare, LLC. A finance charge of 1.5% monthly (18% Annual Percentage Rate) will be charged on any past due balance should the account become 30 days delinquent. If the account is assigned to a third party collection agency for collection, I understand that a charge of

33% of the unpaid balance at the time of assignment will be added to the account to cover the costs and administrative fees. If a suit is filed and taken to court, a 45% fee of the unpaid balance will be

added to the account. I agree to pay the collection charge, plus interest, court costs and attorney fees if applicable. I understand and agree to the above terms.

Signature of responsible party: _____Date: _____

All God's Creatures Holistic Healthcare, LLC

New Patient Information Sheet / Small Animal

Owner's Name: _____ Spouse: _____

Additional people authorized to release health information to: _____

Pet's Information

Pet's Name: _____ Species (circle): Canine Feline

Age or Date of Birth: _____ Sex: _____ (circle) Spayed Neutered

Color: _____ Breed: _____ How long owned pet? _____

If your pet has been seen by other veterinarians, please give name, city, and phone number so medical records can be obtained if needed. If you would prefer we do not contact your previous veterinarian please check this box.

Veterinarian name: _____ Phone: _____

City/State/Zip: _____ Fax: _____

Please list any other important information you would like for us to know about your pet: _____

_____

_____

_____

What is primary reason for visit today?

_____

What is your end goal?

_____

I understand payment is due at time of service and the above information is true to the best of my knowledge.

All God's Creatures Holistic Healing Center
6679 E. State Road 164
Celestine, IN 47521
Phone: 812-536-2276
Text: 812-370-9378

Signed: _____ Date: _____

All God's Creatures Holistic Healthcare

Debra Schafer, DVM

6679 E. State Road 164, Celestine, IN 47521 P: 812.536.2276 allgodscreatureshc@gmail.com

Date _____

Client Name _____

Patient Name _____

Is your pet...

Eating and Drinking Normally: YES / NO

If NO please explain

_____

Normal Urination and/or Bowel Movements: YES / NO

If NO please explain

_____

Vomiting: YES / NO

If YES please explain

_____

Ear Discharge or Shaking Head: YES / NO

If YES please explain

_____

Normal Gait: YES / NO

If NO please explain

_____

Any other abnormal behaviors: YES / NO

If YES please explain

_____

_____

Current medications with dosages:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What diet are you currently feeding? Kibble Canned Cooked Homemade Raw

Brand: _____ Protein/ Main Ingredient _____

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