# PARKWAY ANIMAL HOSPITAL
## CLIENT INFORMATION

Last Name: _____ First: _____ MI: _____

Street Address: _____

(City) (State) (Zip)

Mailing Address: _____

(City) (State) (Zip)

Home phone: _____ Work Phone: _____ Cell : _____

Drivers License: _____ State: _____

E-Mail Address: _____

Spouse/Other: _____

### Employment Information

Employer: _____ Phone: _____

Address: _____

(City) (State) (Zip)

Spouse/Other:

Employer: _____ Phone: _____

Address: _____

(City) (State) (Zip)

### Emergency Contact
(Not the same as above)

Last Name: _____ First: _____ MI: _____

Street Address: _____

(City) (State) (Zip)

Phone: _____ Relationship: _____

How did you hear about us? Phone book / Online / AAHA Referral / Hospital Sign

Referral: _____ / Other: _____

Professional fees are due when services are rendered. We accept cash, checks, VISA, MasterCard, Discover and Care Credit. I understand that I assume responsibility for all charges, past and present, incurred in the care of my animal(s) and they will be paid at the time of release. I also understand that a deposit may be required for surgical treatment or hospitalization. I realize that if my account is not paid in full it will be charged interest at the rate of 18% annually ($0.50 min). Accounts sent to collections will be subject to a $30 fee. There is a return check fee of $35.

**Signature:** _____ **Date:** _____

2655 Edenbower Blvd • Roseburg, OR 97471 • (541) 672-1621