Welcome to Parkway Small Animal & Exotic Hospital

Thank you for giving us the opportunity to care for your pet!
We'll be happy to answer any questions you may have about your pet's health.
To insure the best care possible, please take the time to complete this form.
Thank you!

Pet's Health History

Name of pet _____ Dog ___ Cat ___
Breed _____ Color _____
Birthdate or Approx. Age_____ Male___ Neutered___
Microchip # _____ Female___ Spayed___

Vaccination / Medical History

***Please provide a copy of previous vaccinations and medical record if done elsewhere, if you cannot provide this information please check which of the following are current.**

DAP (Distemper, Adeno virus, Parvo) _____ LEPTO _____ BORDETELLA (Kennel cough) _____
LYME _____ HEARTWORM TEST _____ HEARTWORM PREVENTATIVE_____
RABIES_____ FECAL/GIARDIA _____ FLEA PREVENTATIVE_____
FVRCPC _____ LEUKEMIA _____ LEUKEMIA/FIV TEST _____

Please check any symptoms or problems that you have noticed about your pet:

__ Behavior problems __ Lack of appetite __ Sneezing
__ Bleeding Gums __ Limping __Breathing Problem
__ Loss of Balance __ Vomiting __ Coughing/Gagging
__ Increased Thirst/Urinating __ Scooting __ Weakness
__ Diarrhea __ Scratching __ Lumps/Bumps
__ Seems Depressed __ Shaking Head __ Eye Bulging
__ Decreased Play/Activity __ Slow/Stiff to Rise __ Jumping Less
Other _____

Reason for today's visit: _____
List Medication(s) your pet is on: _____
List of any Chronic Conditions: _____
What is your pet's current Diet: _____

Registration (All Fields Required):

Owner _____ Driver's License # _____
Street Address _____ City/State/Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Emergency Contact Name _____
E-Mail Address _____ Emergency Contact Number _____
List any person(s) authorized to make medical decisions on your behalf _____

How did you learn about our clinic?
__ Website __ Referral
__ Internet __ Facebook
__ MJR Cinema __ Google
__ Sign/Road Other _____

If referred, by whom? _____

Authorization:

I am 18 years of age or older, the owner or agent of the above-described pet(s), and have the authority to execute this consent form. I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet(s). I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical/medical treatment. A finance charge of 2.0% will be added to any account more than 30 days past due. A fee of $35.00 will be applied to your account for any returned checks. If we are required to submit your account to a collection agency, a $25.00 fee will be applied.

Signature _____ **Date** _____

*Method of payment accepted: Cash, Check, Mastercard, Visa, American Express, Discover and Care Credit