

AVIAN AND EXOTIC PET CLINIC OF ROANOKE
3959 ELECTRIC ROAD, SUITE 155, ROANOKE, VA 24018
Telephone: 540-989-4464

I agree to have my pet's vaccinations updated, if needed upon hospital admission. _____

MULTIPLE NEW PET REGISTRATION

Owner Name: _____ **SS# (optional)** _____
Address: _____
City _____ **State:** _____ **Zip Code:** _____ **DL#** _____
Home Phone: _____ **Work Phone:** _____ **Cell#:** _____
Spouse Name: _____ **Phone:** _____
Emergency Contact Name: _____ **Phone:** _____

Name of Pet _____ **Species of Pet** _____
Breed _____ **Color** _____ **Birth date/Age** _____
 Male Neutered Female Spayed
Diet _____ **Hours spent outside** _____
Current Medications _____
Vaccination History (Date & Type of last vaccines, if applicable)

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Current Medications _____
Vaccination History (Date & Type of last vaccines, if applicable)

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet(s). I assume responsibility for all charges incurred in the care of this animal(s). I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical and/or in-hospital treatment. I am aware that full payment is due at time service is rendered. I also am aware that 24 hour notice is required for all rescheduled or canceled appointments or a cancellation fee may be incurred, and that I may receive a late arrival fee or be asked to reschedule the appointment for another day if arriving more than 10 minutes late for a scheduled appointment.

Signature of Owner: _____ **Date:** _____
Print Name of Owner: _____ **Chart#** _____