PATIENT REGISTRATION AND MEDICAL HISTORY

AVIAN AND EXOTIC PET CLINIC OF ROANOKE

Dr. Paul L. Stewart, III
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. X _______

Date: ____________________

REGISTRATION

Owner Name: ______________________________ **SS#:**(Optional)____________________

Address:____

City ____________________ State ______Zip Code: ________ **Driver's License #:(Required)**________________

Home Phone: __________________ Cell#: __________________________

Place of Employment: ____ Work#:______________________

Spouse Name: ______________________________Phone: ___________________

Emergency Contact (other than spouse)______________________________Phone:____________________

How did you learn of our clinic? •Phone Book •Referral: *(by who)* __________________________

•On-line •Other: *(describe)*__________________________

Number of Pets in household:
Dogs _____ Cats _____ Birds _____ Reptiles_____ Rabbits/Rodents_____ Other (specify)______________________

Name of Pet __________________________Species of Pet______________________________________

Breed ______________________________Color______________________ Birth-date____________________

• Male •Neutered • Female • Spayed

Vaccination History (Date &Type of last vaccines and/or previous Veterinary Clinic name and phone#, if applicable) __________

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Name of Pet __________________________Species of Pet______________________________________

Breed ______________________________Color______________________ Birth-date__________________

• Male •Neutered • Female • Spayed

Vaccination History (Date &Type of last vaccines and/or previous Veterinary Clinic name and phone#, if applicable) ___________

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Name of Pet __________________________Species of Pet______________________________________

Breed ______________________________Color______________________ Birth-date____________________

• Male •Neutered • Female • Spayed

Vaccination History ((Date &Type of last vaccines and/or previous Veterinary Clinic name and phone#, if applicable) __________

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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______________________________