



**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# (required) \_\_\_\_\_

Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_ DL# \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Phone: \_\_\_\_\_ SS# \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you learn of our clinic?  Yellow Pages  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  Unknown  Female  Spayed

Vaccination History (Date & Type of last vaccines, if applicable) \_\_\_\_\_

Name of Pet: \_\_\_\_\_ Species of Pet: \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Birth-date: \_\_\_\_\_

Male  Neutered  Unknown  Female  Spayed

Vaccination History (Date & Type of last vaccines, if applicable) \_\_\_\_\_

Name of Pet: \_\_\_\_\_ Species of Pet: \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Birth-date: \_\_\_\_\_

Male  Neutered  Unknown  Female  Spayed

Vaccination History (Date & Type of last vaccines, if applicable) \_\_\_\_\_

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. 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 medical and/or surgical treatment. I also am aware that full payment is due at time service is rendered.

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_