**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. **X** _____

**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:_____

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**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)

_____

_____

**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)

_____

_____

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# _____