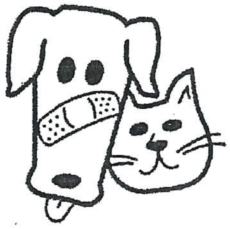


Welcome!

Thank you for giving us the opportunity to care for your pet(s).

We strive to provide the highest quality healthcare available with compassion and convenience

Registration

Owner:______________________________ SS#______________
Address:______________________________ Home Phone:______________
City/State/Zip:______________________________ Cell Phone:______________
Employer:______________________________ Work Phone:______________
Name of Spouse/Other:______________________________ Spouse Phone:______________
Email:__________________ Alternate contact email or phone:______________
Emergency Contact Person:______________________________ Phone:______________

How did you first learn of our hospital? Sign [] Yellow Pages [] Personal Recommendation []
If recommended, who may we thank? ______________________________

Patient Information

Name:______________________________ Breed:______________
Color:______________ Birth Date:______________ Sex:__________ Spayed/Neutered? Yes [] No []
Obtained from: Breeder [] Pet Store [] Shelter [] Stray [] Other [] __________

Name:______________________________ Breed:______________
Color:______________ Birth Date:______________ Sex:__________ Spayed/Neutered? Yes [] No []
Obtained from: Breeder [] Pet Store [] Shelter [] Stray [] Other [] __________

Name:______________________________ Breed:______________
Color:______________ Birth Date:______________ Sex:__________ Spayed/Neutered? Yes [] No []
Obtained from: Breeder [] Pet Store [] Shelter [] Stray [] Other [] __________

Previous Veterinarian where Records may be obtained: ______________________________

Has your pet{s} been treated for any illness within the last 12 months? Yes [] No []
Specify problem{s}, medications and dosages (if known):______________________________
____

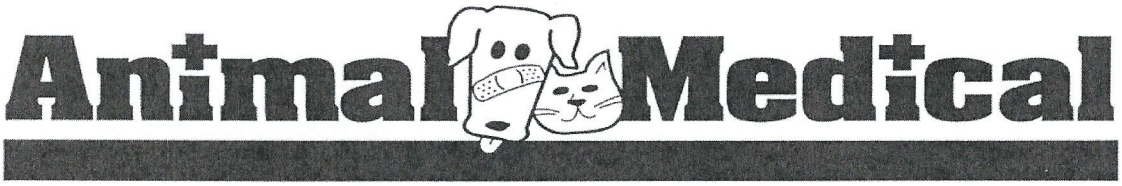
Are there any allergies, illnesses or other health concerns we should be aware of? ______________________________
____

Authorizations & Notices

List the names of **anyone, other than yourself,** who have consent to make medical decisions regarding your pets:
____
I understand that I am responsible for the cost of treatment incurred by these authorizing agents.

I hereby authorize the veterinarian to examine, prescribe for and treat the above described pet{s}. All payments are required at the time of service. I assume responsibility for all charges incurred in the care of this/these animals. I understand that appropriate forms of payment include Cash, Check, Discover, MasterCard, Visa, Debit Cards and Care Credit.

Signature: ______________________________ **Date:** ______________



Animal Medical Clinic of Chesapeake

921 North Battlefield Blvd
Chesapeake, VA 23320
757-548-2000

I have been advised and understand that "continuous care"/ hospitalization as defined by the state legislature (i.e.: the 24-hours presence of a veterinarian) is **not available after normal office hours.** "Continuous care" is available after hours at the emergency clinics. Any animal left in the clinic after normal office hours will be left unattended.

Office Hours are as follows:

Monday	7:30am-7pm
Tuesday	7:30am-6pm
Wednesday	7:30am-6pm
Thursday	7:30am-6pm
Friday	7:30am-6pm
Saturday	8am-12pm

Signature: _____

Date: _____