Briarwood Veterinary Hospital

8213 South Saginaw Street
Grand Blanc, MI 48439
810-695-6055

NEW CLIENT FORM

- **Client Information:**

Owner Name:_____ Spouse's Name:_____

Address:_____City _____Zip:_____

Primary phone & contact name: (_____)_____-_____ _____ ◯ cell or ◯ home

Alternate phone & contact name: (_____)_____-_____ _____ ◯ cell or ◯ home

Email address:_____ Your Date of Birth:_____/_____/_____

Driver's License #:_____ (needed for controlled substances we may prescribe for your pet)

- Do you authorize us to communicate via text regarding your pet? Y N
- Do you authorize Briarwood to use your pet's photo on our Website or Social Media page? Y N
- What is you preferred method of contact? **Text** ◯(___)____-_____ **Call** ◯ (primary # above**) Email**◯

I understand every effort will be made to achieve a successful outcome and to provide safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed above. Furthermore, I agree to pay fees for all services rendered at the time my pet is discharged from the hospital or the service otherwise terminated. I agree to pay for the reasonable cost of collection, attorney fees, and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the hospital is located.

- ✓ **Signature:_____Date:_____/_____/_____**
- ✓ **Printed Name:_____**

Patient Information #1	Patient Information #2
Name:_____ Species: Cat Dog	Name:_____ Species: Cat Dog
Breed:_____ Age/D.O.B_____	Breed:_____ Age/D.O.B_____
Color:_____Spayed or Neutered: Yes or No	Color:_____Spayed or Neutered: Yes or No
Does this pet have and known allergies or vaccine reactions?_____	Does this pet have and known allergies or vaccine reactions?_____
Name of previous veterinary clinic:	Name of previous veterinary clinic:
Patient Information #3	**Patient Information #4**
Name:_____ Species: Cat Dog	Name:_____ Species: Cat Dog
Breed:_____ Age/D.O.B_____	Breed:_____ Age/D.O.B_____
Color:_____Spayed or Neutered: Yes or No	Color:_____Spayed or Neutered: Yes or No
Does this pet have and known allergies or vaccine reactions?_____	Does this pet have and known allergies or vaccine reactions?_____
Name of previous veterinary clinic:	Name of previous veterinary clinic:

ALL FEES ARE DUE AND PAYABLE UPON THE COMPLETION OF SERVICES ON THE DATE THEY ARE RENDERED

Briarwood Veterinary Hospital

8213 South Saginaw Street
Grand Blanc, MI 48439
810-695-6055

Annual Client Update Form Year 2022

Owner Name:_____ Spouse's Name:_____

Address:_____City _____Zip:_____

Primary phone & contact name: (_____)_____-_____ _____ ◯ cell or ◯ home

Alternate phone & contact name: (_____)_____-_____ _____ ◯ cell or ◯ home

Email address:_____ Your Date of Birth:_____/_____/_____

Driver's License #:_____ (needed for controlled substances we may prescribe for your pet)

- **Do you authorize us to communicate via text regarding your pet? Y N**

Name(s) of all current pets:

_____ _____ _____

_____ _____ _____

- **Do you authorize Briarwood to use photos of any pet listed on your account on our Website or Facebook page? ◯ YES ◯ NO**

- **Communication Preference:**

  I prefer to be contacted with updates via .....

  Briarwood App Notification ◯ ◯ Phone _____ Call or Text? _____

- **Reminder Notification:**

  I prefer to be reminded of pet services via……

  Briarwood App Notification ◯ Reminder Card (Mail) ◯ Text ◯ Email ◯

I understand every effort will be made to achieve a successful outcome and to provide safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed above. Furthermore, I agree to pay fees for all services rendered at the time my pet is discharged from the hospital or the service otherwise terminated. I agree to pay for the reasonable cost of collection, attorney fees, and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the hospital is located.

- ✓ **Signature:**_____**Date:**_____/_____/____
- ✓ **Printed Name:**_____

ALL FEES ARE DUE AND PAYABLE UPON THE COMPLETION OF SERVICES ON THE DATE THEY ARE RENDERED